

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

1429

CERTIFICATE OF DEATH

Reg. Dist. No.

01411

1. PLACE OF DEATH a. COUNTY <u>A.A. COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE ON MAGOTHY</u>				c. LENGTH OF STAY IN 1b <u>3 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 178, RTE. 2, SEVERNA PARK</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NORMA</u> Middle <u>R. ARNETT</u> Last <u>—</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
13. FATHER'S NAME <u>JOHN BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>FENTON WHEELER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LOUIS ARNETT 902 ANDREWS AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized edema</u> <u>443X</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>61</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 10/61</u> , 19 <u>61</u> , to <u>Feb 11, 1961</u> , that I last saw the deceased alive on <u>Feb 10/61</u> , 19 <u>61</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saac Miller M.D.</u>				DATE SIGNED <u>12-25-61</u>			
PHYSICIAN'S NAME (Type) <u>DR. SAAC MILLER</u>				ADDRESS <u>BALTO 30 ME 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>A.A.CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hoffmann</u>				ADDRESS <u>3218 HUDSON ST. BALTO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 1961</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH 1918		5. PLACE OF DEATH HOME		6. CAUSE OF DEATH HEART DISEASE	
7. PLACE OF BIRTH NEW YORK		8. OCCUPATION LABORER		9. MARITAL STATUS MARRIED	
10. NAME OF PHYSICIAN DR. J. H. BROWN		11. NAME OF FUNERAL HOME JOHN J. BROWN		12. NAME OF BURIAL PLACE ST. JOHN'S CATHEDRAL	
13. NAME OF NEXT OF KIN JOHN J. BROWN		14. NAME OF WITNESS JOHN J. BROWN		15. NAME OF SIGNER JOHN J. BROWN	
16. NAME OF SIGNER JOHN J. BROWN		17. NAME OF SIGNER JOHN J. BROWN		18. NAME OF SIGNER JOHN J. BROWN	
19. NAME OF SIGNER JOHN J. BROWN		20. NAME OF SIGNER JOHN J. BROWN		21. NAME OF SIGNER JOHN J. BROWN	
22. NAME OF SIGNER JOHN J. BROWN		23. NAME OF SIGNER JOHN J. BROWN		24. NAME OF SIGNER JOHN J. BROWN	
25. NAME OF SIGNER JOHN J. BROWN		26. NAME OF SIGNER JOHN J. BROWN		27. NAME OF SIGNER JOHN J. BROWN	
28. NAME OF SIGNER JOHN J. BROWN		29. NAME OF SIGNER JOHN J. BROWN		30. NAME OF SIGNER JOHN J. BROWN	
31. NAME OF SIGNER JOHN J. BROWN		32. NAME OF SIGNER JOHN J. BROWN		33. NAME OF SIGNER JOHN J. BROWN	
34. NAME OF SIGNER JOHN J. BROWN		35. NAME OF SIGNER JOHN J. BROWN		36. NAME OF SIGNER JOHN J. BROWN	
37. NAME OF SIGNER JOHN J. BROWN		38. NAME OF SIGNER JOHN J. BROWN		39. NAME OF SIGNER JOHN J. BROWN	
40. NAME OF SIGNER JOHN J. BROWN		41. NAME OF SIGNER JOHN J. BROWN		42. NAME OF SIGNER JOHN J. BROWN	
43. NAME OF SIGNER JOHN J. BROWN		44. NAME OF SIGNER JOHN J. BROWN		45. NAME OF SIGNER JOHN J. BROWN	
46. NAME OF SIGNER JOHN J. BROWN		47. NAME OF SIGNER JOHN J. BROWN		48. NAME OF SIGNER JOHN J. BROWN	
49. NAME OF SIGNER JOHN J. BROWN		50. NAME OF SIGNER JOHN J. BROWN		51. NAME OF SIGNER JOHN J. BROWN	
52. NAME OF SIGNER JOHN J. BROWN		53. NAME OF SIGNER JOHN J. BROWN		54. NAME OF SIGNER JOHN J. BROWN	
55. NAME OF SIGNER JOHN J. BROWN		56. NAME OF SIGNER JOHN J. BROWN		57. NAME OF SIGNER JOHN J. BROWN	
58. NAME OF SIGNER JOHN J. BROWN		59. NAME OF SIGNER JOHN J. BROWN		60. NAME OF SIGNER JOHN J. BROWN	
61. NAME OF SIGNER JOHN J. BROWN		62. NAME OF SIGNER JOHN J. BROWN		63. NAME OF SIGNER JOHN J. BROWN	
64. NAME OF SIGNER JOHN J. BROWN		65. NAME OF SIGNER JOHN J. BROWN		66. NAME OF SIGNER JOHN J. BROWN	
67. NAME OF SIGNER JOHN J. BROWN		68. NAME OF SIGNER JOHN J. BROWN		69. NAME OF SIGNER JOHN J. BROWN	
70. NAME OF SIGNER JOHN J. BROWN		71. NAME OF SIGNER JOHN J. BROWN		72. NAME OF SIGNER JOHN J. BROWN	
73. NAME OF SIGNER JOHN J. BROWN		74. NAME OF SIGNER JOHN J. BROWN		75. NAME OF SIGNER JOHN J. BROWN	
76. NAME OF SIGNER JOHN J. BROWN		77. NAME OF SIGNER JOHN J. BROWN		78. NAME OF SIGNER JOHN J. BROWN	
79. NAME OF SIGNER JOHN J. BROWN		80. NAME OF SIGNER JOHN J. BROWN		81. NAME OF SIGNER JOHN J. BROWN	
82. NAME OF SIGNER JOHN J. BROWN		83. NAME OF SIGNER JOHN J. BROWN		84. NAME OF SIGNER JOHN J. BROWN	
85. NAME OF SIGNER JOHN J. BROWN		86. NAME OF SIGNER JOHN J. BROWN		87. NAME OF SIGNER JOHN J. BROWN	
88. NAME OF SIGNER JOHN J. BROWN		89. NAME OF SIGNER JOHN J. BROWN		90. NAME OF SIGNER JOHN J. BROWN	
91. NAME OF SIGNER JOHN J. BROWN		92. NAME OF SIGNER JOHN J. BROWN		93. NAME OF SIGNER JOHN J. BROWN	
94. NAME OF SIGNER JOHN J. BROWN		95. NAME OF SIGNER JOHN J. BROWN		96. NAME OF SIGNER JOHN J. BROWN	
97. NAME OF SIGNER JOHN J. BROWN		98. NAME OF SIGNER JOHN J. BROWN		99. NAME OF SIGNER JOHN J. BROWN	
100. NAME OF SIGNER JOHN J. BROWN		101. NAME OF SIGNER JOHN J. BROWN		102. NAME OF SIGNER JOHN J. BROWN	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, AND IS NOT VALID FOR ANY OTHER PURPOSE.

1430

CERTIFICATE OF DEATH

Reg. Dist. No. 01412

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Meriam</u> Middle <u>Minerva</u> Last <u>BARRETT</u>				4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 March 1878</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USN</u>							
13. FATHER'S NAME <u>George W. TOWNSHEND</u>				14. MOTHER'S MAIDEN NAME <u>Mary California THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Not Available</u>		17. INFORMANT <u>MRS. HERMAN KROL</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>199</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abdominal Neoplasm undermined site</u> DUE TO (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 February, 19 61</u> , to <u>22 February, 19 61</u> , that I last saw the deceased alive on <u>22 February, 19 61</u> , and that death occurred at <u>1010A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital</u> DATE SIGNED <u>22 FEB 61</u>							
ACTUAL SIGNATURE <u>S. Busch</u> M.D. <u>U.S. Naval Hospital</u>				DATE SIGNED <u>22 FEB 61</u>			
PHYSICIAN'S NAME (Type) <u>S. BUSCH LT MC USNR</u>				Address <u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALL HALLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>DAVIDSONVILLE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1430

01413

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1890		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 1, 1915		9. NAME OF SPOUSE Mary E. Brown		10. DATE OF DEATH Dec 10, 1935		11. PLACE OF DEATH Baltimore, Md.		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY None		14. PRESENT ILLNESS None		15. TIME OF DEATH 10:00 AM		16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF REGISTRAR None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF NOTARY None		22. SIGNATURE OF JURY None		23. SIGNATURE OF JUDGE None		24. SIGNATURE OF SHERIFF None	

CHESTERMAN BROWN

1131

Time of day

Location

Time of day

Location

Time of day

Location

Time of day

Location

Time of day

Location

Time of day

Location

Time of day

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1

Reg. Dist. No. 01414

MEDICAL CERTIFICATION

VS AIS (4)
15M 9/55

CERTIFICATE OF DEATH

1-38

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH JAN 31 1938		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		AGE 68	
OCCUPATION RETIRED		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION	
NAME OF DECEASED JOHN DOE		NAME OF NEXT OF KIN JANE DOE	
ADDRESS 123 MAIN ST, BALTIMORE, MD		CITY BALTIMORE	
STATE MARYLAND		COUNTY BALTIMORE	
ZIP CODE 21201		REGISTRAR J. SMITH	
SIGNATURE OF REGISTRAR J. SMITH		SIGNATURE OF DECEASED JOHN DOE	
SIGNATURE OF NEXT OF KIN JANE DOE		SIGNATURE OF WITNESS J. SMITH	
DATE JAN 31 1938		TIME 10:00 AM	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1433

CERTIFICATE OF DEATH

01415✓

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 5 mos. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 516 W. West Street	
3. NAME OF DECEASED (Type or print) First Rose Middle Anna Last Boyd		4. DATE OF DEATH Month 2 Day 9 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Inanition and Dehydration IMMEDIATE CAUSE (a) Chronic Brain Syndrome asso. Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Chronic Brain Syndrome asso. Cerebral Arteriosclerosis DUE TO (c) Chronic Brain Syndrome asso. Cerebral Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While NO at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22/19 60 to 2/9/19 61 , that (I) (we) last saw the deceased alive on 2/9/19 61 , and that death occurred at 5:45 PM from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 2/10/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/61	
23c. NAME OF CEMETERY OR CREMATORY Warrenton		23d. LOCATION (City, town, or county) (State) Warrenton n.e.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Face Baltimore, Md.		25a. REC'D BY REGISTRAR FEB 20 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		25c. DATE FEB 20 61	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 FilmG282 3-14-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01416

1434

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookview Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookview Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arnold Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (Lorraine) Middle Brooks Last Brooks		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 6. 1868</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ships</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph W. Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Tolley - Lourse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-16-3433</u>	
17. INFORMANT <u>Family</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>Coccyx of Stenoch</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coccyx of Stenoch</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>1961</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-27-61</u> , 19 <u>61</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md</u>	
PHYSICIAN'S NAME (Type) <u>Severna Park Md</u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-2-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Meth. Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arnold A.C. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Banane</u>		ADDRESS <u>Severna Park, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Year of Birth

Place of Birth

Age

Sex

Occupation

Marital Status

Education

Religion

Usual Residence

Place of Death

Cause of Death

Immediate Cause of Death

Underlying Cause of Death

Contributing Cause of Death

Period of Illness

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Health Officer

Signature of City Health Officer

1435

CERTIFICATE OF DEATH

Reg. Dist. No. 01417

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 48 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Maryland			
d. STREET ADDRESS 1208 MC KINLEY Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Addie Virginia BRYAN				4. DATE OF DEATH Month Day Year February 3 1961			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Oct. 1912	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Ins. co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME James M. BEALL				14. MOTHER'S MAIDEN NAME Virgie B. KING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-14-1641		17. INFORMANT (Daughter) Shriley V. WILLIAMS	
Address 1208 MC KINLEY Street, Annapolis, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Ovary with widespread Metastasis DUE TO 175.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 31, 1961, to Feb 3, 1961, that I last saw the deceased alive on Feb 3, 1961, and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert D. BELSKY M.D. U. S. NAVAL HOSPITAL							
PHYSICIAN'S NAME (Type) Robert D. BELSKY 11 MC USNR ANNAPOLIS, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Annapolis National		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FIPPING FUNERAL HOME ANNAPOLIS, MD				24a. REC'D BY REGISTRAR DATE FEB 7 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

562

CERTIFICATE OF DEATH

Reg. Dist. No. 02591

1436

1. PLACE OF DEATH a. COUNTY <i>AA Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Darm</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn R9D</i>				c. LENGTH OF STAY IN 1b <i>22 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>884 311 Quarterfield Rd.</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ulysses W. Carroll</i>				4. DATE OF DEATH <i>Feb. 27 1961</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1877</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Benfield Md.</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>John Henry Carroll</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ellen Sappington</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>515-05-5883A</i>		17. INFORMANT <i>Aubrey Smith - Severn</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Corrosion liver -</i> DUE TO (c) <i>5 yrs</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2-3 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>5/24</i> , 19 <i>61</i> , to <i>2/27</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>2/27/61</i> , 19 <i>61</i> , and that death occurred at <i>1:45 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>Linthicum</i>			
DATE SIGNED <i>2/27/61</i>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-3-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Queentown AAC Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. O. Walker</i> ADDRESS <i>1000 Brandon Ave</i>				24a. REC'D BY REGISTRAR <i>MAR 1 6 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01418

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 418 Jefferson St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary ELEANOR CASSADY		DATE OF DEATH Month Day Year February 8 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1889
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Casey		14. MOTHER'S MAIDEN NAME Jeanette Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Florence J. Barry		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) DIABETES MELLITUS ; PERI RECTAL ABSCESS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from Jan. 14, 1961 , to Feb. 7, 1961 , that (I) was last saw the deceased alive on Feb. 7, 1961 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		ATTENDING PHYS. 12:45 A.M. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2/8/61	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-61	
23c. NAME OF CEMETERY OR CREMATORY Annapolis National		23d. LOCATION (City, town or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

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23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Charles A. Rice,	661 W. Barre Street	DATE FEB 20 '61	Arthur S. Kraus

1
FOR STATE
NEW YORK



①

RECEIVED BY THE STATE DEPARTMENT

RECEIVED BY THE STATE DEPARTMENT

1943

1943

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MAINTAINED STATE DEPARTMENT OF HEALTH
IN THE STATE OF NEW YORK
OFFICE OF THE STATE DEPARTMENT OF HEALTH
ALBANY, NEW YORK
JANUARY 1, 1943
TO THE STATE DEPARTMENT OF HEALTH
ALBANY, NEW YORK
FROM THE STATE DEPARTMENT OF HEALTH
ALBANY, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

CERTIFICATE OF DEATH

Reg. Dist. No.

01420

1439

1. PLACE OF DEATH o. COUNTY <i>GA Co</i> <i>md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>md</i> b. COUNTY <i>GA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X RFD 9-Box 412 Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RFD 9-Box 412</i>		d. STREET ADDRESS <i>1 Pasadena</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Walter</i> First <i>Richard</i> Middle <i>Childs</i> Last		4. DATE OF DEATH <i>Feb</i> Month <i>12</i> Day <i>1961</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3-1980</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retiree</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>yes</i>		13. FATHER'S NAME <i>Samuel Childs</i>	
14. MOTHER'S MAIDEN NAME <i>Nelly Ward</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>212-07-9623</i>		17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Bronchopneumonia</i> <i>422.01</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 HOURS</i> <i>1 YEAR</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>BRONCHIECTASIS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-12</i> , 19 <i>61</i> , to <i>—</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>2-12</i> , 19 <i>61</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Arthur Lankford Jr.</i> M.D. <i>2934 MOUNTAIN RD.</i> <i>2-12-61</i>			
ACTUAL SIGNATURE <i>ARTHUR LANKFORD JR MD. PASADENA, MARYLAND</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Rural</i>	<i>Feb 14-61</i>	<i>Baltimore Cemetery</i>	<i>Baltimore City md</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>Frank L. Chapel, Glen Burnie, Md.</i>		DATE <i>FEB 14 '61</i>	<i>Arthur L. Lankford</i>

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VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1440
CERTIFICATE OF DEATH

01421

1. PLACE OF DEATH o. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 8, Box 26		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Route 8, Box 26 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Bond Last Cook		4. DATE OF DEATH Month Feb Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 9, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 1 Days 4 Hours 1 Min.	11. IF UNDER 24 HRS. Months 1 Days 4 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10b. KIND OF BUSINESS OR INDUSTRY Bus Company	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jefferson M. Cook	
14. MOTHER'S MAIDEN NAME Emma Linstad		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-410-9199A		17. INFORMANT William Cook, Route 1, Box 10, Pasadena, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) generalized hypertrophic osteoarthritis		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) generalized hypertrophic osteoarthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1952 to February 4, 1961 , that (I) (we) last saw the deceased alive on February 1, 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin		22b. DATE SIGNED August 4, 1961	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town, or county) (State) Lake Shore, Pasadena, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE FEB 7 '61	
25b. REGISTRAR'S SIGNATURE			

0140

CERTIFICATE OF DEATH

0140

Death occurred on the 1st day of January 1901 at the residence of the deceased, 1234 Main Street, New York City.

Witnessed by the undersigned, a Justice of the Peace for the City and County of New York.

Subscribed and sworn to before me this 1st day of January 1901.

John J. [Signature]
Justice of the Peace

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1441
CERTIFICATE OF DEATH
01422

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN b. <u>1 R 7 D. Edgewater</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 R 7 D. Edgewater</u> d. STREET ADDRESS <u>1 R 7 D. Edgewater</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM E. COOK</u>		4. DATE OF DEATH <u>2-14-1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-26-1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mayo md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ball Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year and dates of service)</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMATION <u>Mrs F. W. Joyce</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) <u>Prostatism (prostatic hypertrophy)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>weeks</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> <u>1961</u> to <u>2/10</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> <u>1961</u> , and that death occurred at <u>5:15 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u>		22b. DATE SIGNED <u>2/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>		22d. ADDRESS <u>121 EATHVORAZ ST ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-17-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Andrews Cemt</u>	23d. LOCATION (City, town or county) (State) <u>Mayo md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Crimmopolis md</u>		DATE <u>FEB 16 '61</u>	

8410

11-11

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 20 Film 281 2-28-61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01423

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belle Haven, Pasadena		c. LENGTH OF STAY IN 1b Few hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 1206 Guilford Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) May wood Rd and Beach Circle Rd.				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roy Lee Crews				4. DATE OF DEATH February 11th. 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/1924	
9. AGE (In years last birthday) 36		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Department head at Penn Fruit Store.				10b. KIND OF BUSINESS OR INDUSTRY West Virginia.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton Crews				14. MOTHER'S MAIDEN NAME Riva Bisham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, Last world war.				16. SOCIAL SECURITY NO. 236-22-9695		17. INFORMANT Mrs. Iris Crews (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication 891.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inhalation of auto exhaust fumes DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Inhalation of carbon monoxide			
20c. TIME OF INJURY Hour a.m. 8 x p.m. 2/11/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parked car		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King Jr MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Bradley King Jr MD				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED Feb. 11, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15th Feb. 1961		22c. NAME OF CEMETERY OR CREMATORY Basham Family Cemetery		22d. LOCATION (City, town, or country) (State) Coal Ridge, W. Virginia	
23. FUNERAL DIRECTOR R. D. Singleton				24a. RECEIVED BY REGISTRAR Feb 14 1961		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	
ADDRESS Glen Burnie, Maryland				DATE			

MEDICAL CERTIFICATION

02
2



1442

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01424

1443

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERNDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERNDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 3rd Ave</u>				d. STREET ADDRESS <u>4 3rd Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>M.</u> Last <u>CRITZMAN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>Wm. Bremore</u>				14. MOTHER'S MAIDEN NAME <u>CROTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
INFORMANT <u>DAUGHTER</u> Address <u>SAME</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>416X</u> IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>50 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3.22</u> , 19 <u>46</u> to <u>2-9-60</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>2-7-60</u> , 19 <u>—</u> , and that death occurred at <u>9:00</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan Racusin</u>				ADDRESS (Street, city or town, state) <u>206 S. Gilmore St</u> DATE SIGNED <u>2-11-61</u>			
PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>				BUILD <u>BALTO 23 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Steenman</u> ADDRESS <u>6067 Hayford Rd</u>				24a. REC'D BY REGISTRAR <u>FEB 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

STATE OF TEXAS
COUNTY OF DALLAS

1443

DALLAS

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WILLIAM H. HAYES

WILLIAM H. HAYES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1444

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01425

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN 1b X Brooklyn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5800 Ritchie St.		d. STREET ADDRESS 5800 Ritchie St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clara A. Crouch		4. DATE OF DEATH February 2, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1870	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Little		14. MOTHER'S MAIDEN NAME Julia Voyce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Family Same	
17. INFORMANT Family Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Serility 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs Undet			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1959 to Feb 2, 1961 , that (I) (we) last saw the deceased alive on Jan 30, 1961 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy		22b. DATE SIGNED 2-5-61	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M.D.		22d. ADDRESS 1264 Francis Avenue; Balto. 27, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Brooklyn, Anne Arundel, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave.		25a. REC'D BY REGISTRAR FEB 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

1144

Ande Arnold

Married

Ande Arnold

Brooklyn

Brooklyn

3200 11th St.

3200 11th St.

Oliver A. Brown

Oliver A. Brown

Female White

Female White

Home Work

Home Work

Samuel Little

Samuel Little

No

Female White

[Faint, mostly illegible text in the lower half of the page, possibly bleed-through from the reverse side.]

1
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
1445					CERTIFICATE OF DEATH					Reg. Dist. No. 01426									
1. PLACE OF DEATH o. COUNTY <i>A.A.</i> MIDDLE					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>AA.</i>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. PLEASANT</i>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. PLEASANT</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>John S. Cunningham</i>					4. DATE OF DEATH Month <i>2</i> Day <i>11</i> Year <i>1961</i>														
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-7-90</i>		9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FIREMAN</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>B.C.F.C.</i>					11. BIRTHPLACE (State or foreign country) <i>MD</i>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>John</i>					14. MOTHER'S MAIDEN NAME <i>Mary Susan</i>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					INFORMANT <i>Family</i> Address <i>same</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.00</i> DUE TO <i>Arterio-sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>3-4 years</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>3-4 years</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>9/18</i> , 19 <i>54</i> , to <i>2/11</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>2/6</i> , 19 <i>61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.																			
ACTUAL SIGNATURE <i>Harry Deibel</i>					ADDRESS (Street, city or town, state) <i>1226 Hanover St. Balto 30 Md</i>										DATE SIGNED				
PHYSICIAN'S NAME (Type) <i>DR. HARRY DEIBEL</i>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2</i>					22b. DATE THEREOF <i>2-15-61</i>					22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>					22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. ...</i>					ADDRESS <i>130 E. ...</i>					24a. REC'D BY REGISTRAR DATE <i>FEB 15 '61</i>					24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>				

14-00000-143-RECEIVED 1981 JAN 15 10 57 AM

2457

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1446

01427

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 yrs. 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS 402 Main Court ?	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Davis		4. DATE OF DEATH Month 2 Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 03 Days X	IF UNDER 24 HRS. Hours 2 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? Isabella ?	
13. FATHER'S NAME George Davis		14. MOTHER'S MAIDEN NAME Isabella ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 1/23/ 1957 to 2/22/ 1961 , that (I) (we) last saw the deceased alive on 2/22/ 1961 and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 2/23/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF March 1	
23c. NAME OF CEMETERY OR CREMATORY mt Calver		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Habley</i>		25a. REC'D BY REGISTRAR W. H. Habley	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Habley</i>		25c. DATE MAR 2 '61	

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1447 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

01428

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 404 Second Avenue, S.W.		e. STREET ADDRESS 506 Monroe Circle	
3. NAME OF DECEASED (Type or print) First Hiram Middle Disney Last Disney		4. DATE OF DEATH Month Feb. Day 25 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1873
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	11. IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A.A.Co. Roads		10b. KIND OF BUSINESS OR INDUSTRY County Employee	
11. BIRTHPLACE (State or foreign country) AA County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilson Disney		14. MOTHER'S MAIDEN NAME Angeline Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs Mamie Rurdham, same as 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arterio Sclerosis DUE TO (c) Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 year 2 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1941 , to Feb 25 , 1961, that (I) (we) last saw the deceased alive on Jan 4 , 1961, and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James S. Billingslea		22b. DATE SIGNED Feb 27 1961	
22c. PHYSICIAN'S NAME (Type) James S. Billingslea, M.D.		22d. ADDRESS 108 Central Ave. NW, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/28/61	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	23d. LOCATION (City, town, or county) (State) Elkridge Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR DATE MAR 2 '61	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1443
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01429

1. PLACE OF DEATH a. COUNTY <i>AnneArundel</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>D. C.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale, Md. Near Churchtown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <i>Deale Beach Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Alton</i> Last <i>Dorsey</i>			4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1961</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12/8/1903</i>	9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BANK</i>		11. BIRTHPLACE (State or foreign country) <i>Churchtown, Md.</i>	
13. FATHER'S NAME <i>Charles William Dorsey</i>			14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Franklin</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>WWII 1942-45</i>		16. SOCIAL SECURITY NO. <i>212-09-0443</i>		17. INFORMANT Name <i>MARY E. FRANKLIN</i> Address <i>Churchtown, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Coronary artery disease & bronchial asthma</i> DUE TO (c) _____ (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Alcoholism</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Willard F. Smith</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>WILLARD F. SMITH, MD</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>FEB 6, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>				(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>T A Hardesty + Son</i>			ADDRESS <i>Galesville Md</i>		
24a. REC'D BY REGISTRAR <i>FEB 7 '61</i>			24b. REGISTRAR'S SIGNATURE <i>Clinton L. Farris</i>		

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MEDICAL CERTIFICATION

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1 1451 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01431

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1161 Eastport Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>RYLAND</u> Last <u>DUNAWAY</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>24</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Const.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rolston Dunaway</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-05-0563</u>	
17. INFORMANT <u>Mrs Helen M Dunaway- Wife- Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular insufficiency</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/20</u> , 19 <u>61</u> , to <u>2/23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/24/61</u>			
ACTUAL SIGNATURE <u>Richard I. Hochman</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard I Hochman MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 28 1961</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Richard S. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01432

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN 1b Severna Park d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 1 Box 345 Severna Park, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY A.A.Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS Rt. 1 Box 345 Severna Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Naomi Marie Dunn			4. DATE OF DEATH Month Day Year February 20th 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1886	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper			11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		
13. FATHER'S NAME Joseph L. Dunn			14. MOTHER'S MAIDEN NAME Annie Kehoe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)			16. SOCIAL SECURITY NO. Mary E. Dunn Rt. 1 Box 345 Severna Park		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory (Tracheal) obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Parkinson's Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350X			INTERVAL BETWEEN ONSET AND DEATH 3 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 1960, to February 19 61 that (I) (we) last saw the deceased alive on Feb. 16 1961 , and that death occurred at 3P.M. from the causes and on the date stated above.					
22a. SIGNATURE Francis I. Codd			22b. DATE SIGNED 2-21-61		
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.			22d. ADDRESS Severna Park, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/23/61		
23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck			25a. REC'D BY REGISTRAR FEB 23 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01453

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN 1b 52 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) Camp Meade Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Camp Meade Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last WESLEY DURNER				4. DATE OF DEATH Month Day Year February 12th 1961											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4th February 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed				11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Durner						14. MOTHER'S MAIDEN NAME Mary Watts									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. May Disney (daughter) Glen Burnie, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO Hypertension (b) Diabetes (c) —										INTERVAL BETWEEN ONSET AND DEATH 4-6 yrs 10 yrs 2-4 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Glen Burnie		(County) Maryland		(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to Feb. 12, 1961 , that (I) (we) last saw the deceased alive on 2/12 19 61 , and that death occurred at 10 P. M, from the causes and on the date stated above.															
22a. SIGNATURE Chas. L. Ball Jr						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-12-61							
22c. PHYSICIAN'S NAME (Type) Chas. L. Ball Jr						22d. ADDRESS Glen Burnie, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 16th Feb. '61		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery				23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Richard P. Bingle						ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE FEB 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Evans					

01433

CERTIFICATE OF DEATH

1933

State of New York, County of New York, City of New York, Borough of Manhattan, Precinct of Central Park West.

On the 15th day of May, 1933, at the City of New York, Borough of Manhattan, Precinct of Central Park West.

That I, the undersigned, a duly qualified and licensed physician, do hereby certify that the above named person died on the 15th day of May, 1933, at the City of New York, Borough of Manhattan, Precinct of Central Park West.

Attest my hand and seal this 15th day of May, 1933.

Signature of Physician

Witness my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

Signature of Registrar

Attest my hand and seal this 15th day of May, 1933.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1454
CERTIFICATE OF DEATH
01434

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 10 Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Dead on arrival) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First E. Middle Saunders Last DUVALL				4. DATE OF DEATH Month February Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 15, 1901	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 11 Hours 19 Min. 61		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U S Gov.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ringgold Duvall			
14. MOTHER'S MAIDEN NAME Mary Willard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-16-0774		17. INFORMANT Mrs. Cecile K. Duvall- Wife- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Caudice aneur 416X DUE TO (b) Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH instant. 20 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that (I) John L. Hedeman attended the deceased from July 1955 to February 1961 , that (I) last saw the deceased alive on Feb. 10 1961 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John L. Hedeman M.D.				22b. DATE SIGNED 2/13/61			
22c. PHYSICIAN'S NAME (Type) John L. Hedeman				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 14, 61		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				25a. REC'D BY REGISTRAR FEB 15 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Page 1 of 1

Application Number: 100-441100

1455

CERTIFICATE OF DEATH

Reg. Dist. **N01455**

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Somerville		c. LENGTH OF STAY IN 1b 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Lynn Middle Edie Last Emmanuel		4. DATE OF DEATH Month 2 Day 12 Year 1961	
5. SEX F	6. COLOR OR RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 31/60
9. AGE (In years lost birthday) 1 yrs. 1 Months 1 Days 1 Hours 1 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Emmanuel		14. MOTHER'S MAIDEN NAME Sidney Pearl Edwards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Sidney Pearl Edwards Odenton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cate Breach Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c) 491X		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 9 , 19 61 , to Feb 12 , 19 61 , that I last saw the deceased alive on Feb 9 , 19 61 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Lipsky M.D.		DATE SIGNED 2/12/61	
PHYSICIAN'S NAME (Type) JOSEPH LIPSKY			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-14-1961	Mathedonia	Odenton Md
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS 2003203x5	
24a. REC'D BY REGISTRAR FEB 15 '61		24b. REGISTRAR'S SIGNATURE W. Reese	

County of Clark State of Nevada
I, John D. Smith, Registrar of the County of Clark, State of Nevada, do hereby certify that on the 10th day of April, 1913, at Las Vegas, Nevada, John D. Smith, of the County of Clark, State of Nevada, died at the age of 45 years, of Heart Disease, the result of Coronary Artery Sclerosis, and that the deceased was born on the 15th day of August, 1868, at Las Vegas, Nevada, and was a resident of the County of Clark, State of Nevada, at the time of his death.

Witness my hand and the seal of said County at Las Vegas, Nevada, this 10th day of April, 1913.
John D. Smith
Registrar of the County of Clark, State of Nevada
Attest:
John D. Smith
Registrar of the County of Clark, State of Nevada

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

01436

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ANN Last ENDERS				4. DATE OF DEATH Month FEBRUARY Day 13 Year 19 61			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1879	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Crump				14. MOTHER'S MAIDEN NAME Ann Riker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Husband Quarters # 1239-A Ft Geo G. Meade, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) examined the deceased 13 Feb 19 61 and that death occurred at 8:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Nathaniel S. Beard				22b. DATE SIGNED 13 Feb 61			
22c. PHYSICIAN'S NAME (Type) NATHANIEL S. BEARD, Capt., M.C.				22d. ADDRESS US Army Hosp Ft Geo G. Meade, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-14-1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Ware				ADDRESS Glen Burnie, Md		25a. REC'D BY REGISTRAR DATE FEB 15 '61	
				25b. REGISTRAR'S SIGNATURE William S. Thoms			

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CERTIFICATE OF DEATH

01437

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis MD</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>526 Third St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Elsie</i> Middle <i>M.</i> Last <i>Engelke</i>				4. DATE OF DEATH Month <i>2</i> - Day <i>8</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 17th 1875</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>William Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Dora Woolford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs Ethel M. Schultz</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ischaemic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>Several yrs.</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2-8-</i> 1961, to <i>2-8-</i> 1961, that (I) last saw the deceased alive on <i>2-8-</i> 1961, and that death occurred at <i>7:45</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Mr. P. Stephens</i>				22b. DATE <i>2/8/61</i>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-10-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayla Sons</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 14 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CERTIFICATE OF DEATH

1951

STATE OF TEXAS
COUNTY OF DALLAS

WITNESSES

[Faint, illegible text, likely bleed-through from the reverse side of the document]

CERTIFICATE OF DEATH

Reg. Dist. No. 01438

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Maryland		d. STREET ADDRESS 196 DUKE OF GLOUCESTER STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM KEITH ENRIGHT		4. DATE OF DEATH Month FEBRUARY Day 27 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 FEBRUARY 1909
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 27 Hours 19 Min. 61	IF UNDER 24 HRS. Months 52 Days 27 Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER USMC		10b. KIND OF BUSINESS OR INDUSTRY COLORADO	11. BIRTHPLACE (State or foreign country) UNITED STATES
13. FATHER'S NAME JOHN ALBERT ENRIGHT		14. MOTHER'S MAIDEN NAME ROSE AGNES BENSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 216-38-5087	
17. INFORMANT (Wife) DOLORES F. ENRIGHT ST., ANNAPOLIS, MD.		18. DUKE OF GLOUCESTER ST., ANNAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 42 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 January, 1961 , to 27 February, 1961 , that I last saw the deceased alive on 27 February, 1961 , and that death occurred at 3:23A M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 196 DUKE OF GLOUCESTER ST., ANNAPOLIS, MD. DATE SIGNED Robert D. Belsky			
ACTUAL SIGNATURE Robert D. Belsky		M.D. _____	
PHYSICIAN'S NAME (Type) Robert D. BELSKY, LT MC USNR U. S. Naval Hospital, Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 1 1961	
22c. NAME OF CEMETERY OR CREMATORY Naval Academy		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		ADDRESS Annapolis Md.	
24a. REC'D BY REGISTRAR DATE MAR 1 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A1S (4)
15M 9/55

CERTIFICATE OF DEATH

1958

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. RACE [REDACTED]		5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]		7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]		9. TIME OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]		11. MANNER OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]		13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]		16. SIGNATURE OF JUDGE [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF REGISTRAR [REDACTED]		19. SIGNATURE OF [REDACTED]		20. SIGNATURE OF [REDACTED]		21. SIGNATURE OF [REDACTED]		22. SIGNATURE OF [REDACTED]		23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]		25. SIGNATURE OF [REDACTED]		26. SIGNATURE OF [REDACTED]		27. SIGNATURE OF [REDACTED]		28. SIGNATURE OF [REDACTED]		29. SIGNATURE OF [REDACTED]		30. SIGNATURE OF [REDACTED]		31. SIGNATURE OF [REDACTED]		32. SIGNATURE OF [REDACTED]		33. SIGNATURE OF [REDACTED]		34. SIGNATURE OF [REDACTED]		35. SIGNATURE OF [REDACTED]		36. SIGNATURE OF [REDACTED]		37. SIGNATURE OF [REDACTED]		38. SIGNATURE OF [REDACTED]		39. SIGNATURE OF [REDACTED]		40. SIGNATURE OF [REDACTED]		41. SIGNATURE OF [REDACTED]		42. SIGNATURE OF [REDACTED]		43. SIGNATURE OF [REDACTED]		44. SIGNATURE OF [REDACTED]		45. SIGNATURE OF [REDACTED]		46. SIGNATURE OF [REDACTED]		47. SIGNATURE OF [REDACTED]		48. SIGNATURE OF [REDACTED]		49. SIGNATURE OF [REDACTED]		50. SIGNATURE OF [REDACTED]		51. SIGNATURE OF [REDACTED]		52. SIGNATURE OF [REDACTED]		53. SIGNATURE OF [REDACTED]		54. SIGNATURE OF [REDACTED]		55. SIGNATURE OF [REDACTED]		56. SIGNATURE OF [REDACTED]		57. SIGNATURE OF [REDACTED]		58. SIGNATURE OF [REDACTED]		59. SIGNATURE OF [REDACTED]		60. SIGNATURE OF [REDACTED]		61. SIGNATURE OF [REDACTED]		62. SIGNATURE OF [REDACTED]		63. SIGNATURE OF [REDACTED]		64. SIGNATURE OF [REDACTED]		65. SIGNATURE OF [REDACTED]		66. SIGNATURE OF [REDACTED]		67. SIGNATURE OF [REDACTED]		68. SIGNATURE OF [REDACTED]		69. SIGNATURE OF [REDACTED]		70. SIGNATURE OF [REDACTED]		71. SIGNATURE OF [REDACTED]		72. SIGNATURE OF [REDACTED]		73. SIGNATURE OF [REDACTED]		74. SIGNATURE OF [REDACTED]		75. SIGNATURE OF [REDACTED]		76. SIGNATURE OF [REDACTED]		77. SIGNATURE OF [REDACTED]		78. SIGNATURE OF [REDACTED]		79. SIGNATURE OF [REDACTED]		80. SIGNATURE OF [REDACTED]		81. SIGNATURE OF [REDACTED]		82. SIGNATURE OF [REDACTED]		83. SIGNATURE OF [REDACTED]		84. SIGNATURE OF [REDACTED]		85. SIGNATURE OF [REDACTED]		86. SIGNATURE OF [REDACTED]		87. SIGNATURE OF [REDACTED]		88. SIGNATURE OF [REDACTED]		89. SIGNATURE OF [REDACTED]		90. SIGNATURE OF [REDACTED]		91. SIGNATURE OF [REDACTED]		92. SIGNATURE OF [REDACTED]		93. SIGNATURE OF [REDACTED]		94. SIGNATURE OF [REDACTED]		95. SIGNATURE OF [REDACTED]		96. SIGNATURE OF [REDACTED]		97. SIGNATURE OF [REDACTED]		98. SIGNATURE OF [REDACTED]		99. SIGNATURE OF [REDACTED]		100. SIGNATURE OF [REDACTED]	
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1 1459 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 1 Film 6281 2-21-61 et CERTIFICATE OF DEATH Reg. Dist. No. 01439

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. LENGTH OF STAY IN 1b <u>2 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private home"</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>FABIE</u> Last <u>FABIE</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1911</u>	9. AGE (In years lost birthday) <u>49</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wehn</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Butcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mr. Aloysius Fabie (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOPIS GENERAL</u> DUE TO (b) <u>CARCINOMA of Cervix Uteri</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 12, 1960</u> to <u>Feb 8, 1961</u> , that I last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Taler, M.D.</u>				ADDRESS (Street, city or town, state) <u>102 Bd A Blvd. N.E.</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER, M.D.</u>				DATE SIGNED <u>2-8-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A.A.Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gance</u>				ADDRESS <u>4001 Ritchie Hwy.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14250

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10/15/1914</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. DISEASE OR INJURY <i>ANGINA PECTORIS</i>		9. MEDICAL HISTORY <i>None</i>	
10. OCCUPATION <i>None</i>		11. HABIT <i>None</i>		12. PREVIOUS ILLNESS <i>None</i>	
13. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		14. SIGNATURE OF WITNESSES <i>John J. Smith</i>		15. SIGNATURE OF DECEASED <i>John J. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		17. SIGNATURE OF CLERK <i>John J. Smith</i>		18. SIGNATURE OF JURY <i>John J. Smith</i>	
19. SIGNATURE OF JURY <i>John J. Smith</i>		20. SIGNATURE OF JURY <i>John J. Smith</i>		21. SIGNATURE OF JURY <i>John J. Smith</i>	
22. SIGNATURE OF JURY <i>John J. Smith</i>		23. SIGNATURE OF JURY <i>John J. Smith</i>		24. SIGNATURE OF JURY <i>John J. Smith</i>	
25. SIGNATURE OF JURY <i>John J. Smith</i>		26. SIGNATURE OF JURY <i>John J. Smith</i>		27. SIGNATURE OF JURY <i>John J. Smith</i>	
28. SIGNATURE OF JURY <i>John J. Smith</i>		29. SIGNATURE OF JURY <i>John J. Smith</i>		30. SIGNATURE OF JURY <i>John J. Smith</i>	
31. SIGNATURE OF JURY <i>John J. Smith</i>		32. SIGNATURE OF JURY <i>John J. Smith</i>		33. SIGNATURE OF JURY <i>John J. Smith</i>	
34. SIGNATURE OF JURY <i>John J. Smith</i>		35. SIGNATURE OF JURY <i>John J. Smith</i>		36. SIGNATURE OF JURY <i>John J. Smith</i>	
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49. SIGNATURE OF JURY <i>John J. Smith</i>		50. SIGNATURE OF JURY <i>John J. Smith</i>		51. SIGNATURE OF JURY <i>John J. Smith</i>	
52. SIGNATURE OF JURY <i>John J. Smith</i>		53. SIGNATURE OF JURY <i>John J. Smith</i>		54. SIGNATURE OF JURY <i>John J. Smith</i>	
55. SIGNATURE OF JURY <i>John J. Smith</i>		56. SIGNATURE OF JURY <i>John J. Smith</i>		57. SIGNATURE OF JURY <i>John J. Smith</i>	
58. SIGNATURE OF JURY <i>John J. Smith</i>		59. SIGNATURE OF JURY <i>John J. Smith</i>		60. SIGNATURE OF JURY <i>John J. Smith</i>	
61. SIGNATURE OF JURY <i>John J. Smith</i>		62. SIGNATURE OF JURY <i>John J. Smith</i>		63. SIGNATURE OF JURY <i>John J. Smith</i>	
64. SIGNATURE OF JURY <i>John J. Smith</i>		65. SIGNATURE OF JURY <i>John J. Smith</i>		66. SIGNATURE OF JURY <i>John J. Smith</i>	
67. SIGNATURE OF JURY <i>John J. Smith</i>		68. SIGNATURE OF JURY <i>John J. Smith</i>		69. SIGNATURE OF JURY <i>John J. Smith</i>	
70. SIGNATURE OF JURY <i>John J. Smith</i>		71. SIGNATURE OF JURY <i>John J. Smith</i>		72. SIGNATURE OF JURY <i>John J. Smith</i>	
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82. SIGNATURE OF JURY <i>John J. Smith</i>		83. SIGNATURE OF JURY <i>John J. Smith</i>		84. SIGNATURE OF JURY <i>John J. Smith</i>	
85. SIGNATURE OF JURY <i>John J. Smith</i>		86. SIGNATURE OF JURY <i>John J. Smith</i>		87. SIGNATURE OF JURY <i>John J. Smith</i>	
88. SIGNATURE OF JURY <i>John J. Smith</i>		89. SIGNATURE OF JURY <i>John J. Smith</i>		90. SIGNATURE OF JURY <i>John J. Smith</i>	
91. SIGNATURE OF JURY <i>John J. Smith</i>		92. SIGNATURE OF JURY <i>John J. Smith</i>		93. SIGNATURE OF JURY <i>John J. Smith</i>	
94. SIGNATURE OF JURY <i>John J. Smith</i>		95. SIGNATURE OF JURY <i>John J. Smith</i>		96. SIGNATURE OF JURY <i>John J. Smith</i>	
97. SIGNATURE OF JURY <i>John J. Smith</i>		98. SIGNATURE OF JURY <i>John J. Smith</i>		99. SIGNATURE OF JURY <i>John J. Smith</i>	
100. SIGNATURE OF JURY <i>John J. Smith</i>		101. SIGNATURE OF JURY <i>John J. Smith</i>		102. SIGNATURE OF JURY <i>John J. Smith</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundle</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>				c. LENGTH OF STAY IN 1b <u>12 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence Box 465 Route #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>FRANCIS</u> Middle <u>Fearson Jr.</u> Last				4. DATE OF DEATH <u>February</u> Month <u>10</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 7, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Howard Francis Fearson</u>				14. MOTHER'S MAIDEN NAME <u>Emma L. Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>WW I</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>5790 34066</u>		17. INFORMANT <u>Mrs. Hazel S. Fearson, Route #1, Box 465, Deale, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>60</u> , to <u>Feb 10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>61</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Shady side, Md.</u> DATE SIGNED <u>2/10/61</u>							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u> ADDRESS <u>Riverdale, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

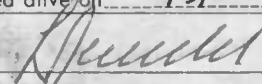
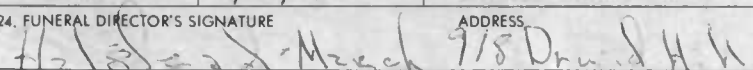
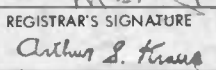
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 must be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1461

01441

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10 years 8 mos. 23 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			d. STREET ADDRESS 436 North Calhoun Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle (A) Last Franklin			4. DATE OF DEATH Month 2 Day 5 Year 1961		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1886	9. AGE (In years and days) 74 yrs.	IF UNDER 1 YEAR Months 7 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jerry?			14. MOTHER'S MAIDEN NAME Martha ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Generalized Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour 10 p. m. 19 61	20d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory street office bldg.	20f. (City or town) _____	(County) _____	(State) _____
21. I certify that (I) (this hospital) attended the deceased from 5/12/1950 to 2/5/1961 that (I) (we) last saw the deceased alive on 2/5/1961 and that death occurred at 3:15 AM from the causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED February 6, 1961	22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		
22d. ADDRESS Crownsville State Hospital, Maryland		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/11/61	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION (City, town, or county) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE 		25a. RECEIVED BY REGISTRAR DATE FEB 14 1961	25b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1021

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1. *Chlorophyll a* (Chl *a*)

1351

01/11/2001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

1462 Item 2 Film 62-21-01 et

1462

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01442

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSTVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
c. LENGTH OF STAY IN lb since 8/27/60		d. STREET ADDRESS POB 106	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSTVILLE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ABRAHAM First GATHER Middle GAITHER Last		4. DATE OF DEATH Month 2 Day 10 Year 1961	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS GAITHER		14. MOTHER'S MAIDEN NAME ELLA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. /	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CHRONIC BRAIN SYNDROME ASS. C. CEREBRAL ARTERIOSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/27/60 19 61 to 2/10/61 19 61 that (I) (we) last saw the deceased alive on 2/10/61 19 61 and that death occurred at 9:00 M, from the causes and on the date stated above.			
22a. SIGNATURE L. BENEDICT M. D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M. D.		22d. ADDRESS CROWNSTVILLE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/61	
23c. NAME OF CEMETERY OR CREMATORY Ashbury		23d. LOCATION (City, town, or county) (State) Howard Co near Savage Md	
24. FUNERAL DIRECTOR'S SIGNATURE RIOCLEY-SELBY ADDRESS LAUREL-MD		25a. REC'D BY REGISTRAR FEB 16 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1462

CENTRE AIR OF DEAR

THE AIR FORCE OF THE UNITED STATES



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CHIEF OF STAFF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1463

CERTIFICATE OF DEATH

01443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 'MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md 30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ellerslie Rd</u>		d. STREET ADDRESS <u>Ellerslie Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Agota</u> First <u>Goldweiss</u> Middle <u>Goldweiss</u> Last <u>Goldweiss</u>		4. DATE OF DEATH <u>2-20-61</u> Month <u>2</u> Day <u>20</u> Year <u>19</u>	
5. SEX <u>F.</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Dec. 18, 1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Antonius Berkoskis</u>		14. MOTHER'S MAIDEN NAME <u>Maue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>Chove</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastasis</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of uterus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19____, to <u>1961</u> , 19____, that I last saw the deceased alive on <u>2-19-61</u> , 19____, and that death occurred at <u>11:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, State) <u>Severna Park md 2-20-61</u>	
DATE SIGNED <u>2-20-61</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or County) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Baranco</u>		ADDRESS <u>Severna Park md</u>	
24a. REC'D BY REGISTRAR <u>Feb 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1944

BOMBING

RECEIVED
JAN 10 1945

NAME OF DECEASED [Faint text, possibly "JOHN B. BOMBING"]	
SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "35"]	
DATE OF BIRTH [Faint text, possibly "1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Engineer"]	
CAUSE OF DEATH [Faint text, possibly "BOMBING"]	
PLACE OF DEATH [Faint text, possibly "Baltimore, Md."]	
TIME OF DEATH [Faint text, possibly "10:00 PM"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF WITNESS [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF DECEASED [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF BURIAL OFFICER [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF CHURCH OFFICER [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF MINISTER [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF CLERGYMAN [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF RABBI [Faint text, possibly "J. B. BOMBING"]	
SIGNATURE OF OTHER [Faint text, possibly "J. B. BOMBING"]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01444											
1. PLACE OF DEATH e. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Shadyside						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchton					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First ROWEL Middle CORDELL Last GRAY						Month February Day 6 Year 19 61					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 6 1960		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) (Baltimore City)		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME John Frey						14. MOTHER'S MAIDEN NAME Anna R Forrester					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						17. INFORMANT Address Thos Forrester Leesville Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and Malnutrition. 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/7/61 Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/14/61		22c. NAME OF CEMETERY OR CREMATORY Chews		22d. LOCATION (City, town, or country) (State) West River Md.			
23. FUNERAL DIRECTOR Germond Hardisty ADDRESS Leesville Md						24a. REC'D BY REGISTRAR DATE FEB 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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1910

James Andrew

Mayland

Spencer

Clouston

Coleridge

Dec 1910

John Gray

Walter R. Forrester

Phonographs and Tactile Notes.

1910

1910

1910

1910

James Andrew
Mayland
Spencer
Clouston
Coleridge
Dec 1910
John Gray
Walter R. Forrester
Phonographs and Tactile Notes.

James Andrew
Mayland
Spencer
Clouston
Coleridge
Dec 1910
John Gray
Walter R. Forrester
Phonographs and Tactile Notes.

1905

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Amphiprion

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1466

01446

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Anne Arundel g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Severn h. STREET ADDRESS Bo x-187 i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie First HANSBERRY Middle February Last 9 DATE OF DEATH 19 61 Month 9 Day 19 61 Year		4. DATE OF DEATH February 9 19 61	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1899 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (County & State, or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hudson Johnson 14. MOTHER'S MAIDEN NAME Ida Nelson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Madeline Brown 16. SOCIAL SECURITY NO. Same 17. INFORMANT Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac decompensation DUE TO (c) Hypertensive cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. Uremia. Bilateral cataracts. Chronic leg ulcers.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961 to Feb. 8, 1961 , that (I) (we) last saw the deceased alive on Feb. 8, 1961 , and that death occurred at 1:25 A.M. from the causes and on the date stated above.		22a. SIGNATURE Lionel McH. Mapp 22b. DATE 1:25 A.M. 22c. PHYSICIAN'S NAME (Type) Lionel McH. Mapp 22d. ADDRESS 20 Dean St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 2/11/61 23c. NAME OF CEMETERY OR CREMATORY Private Burial Lot East End 23d. LOCATION (City, town or county) VA.		24. FUNERAL DIRECTOR'S SIGNATURE Arington S. Phillips ADDRESS 1808 N. Monroe St. 25a. REC'D BY REGISTRAR FEB 14 '61 25b. REGISTRAR'S SIGNATURE Arington S. Phillips	

01446

01446

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of 100,000

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100,000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1467

CERTIFICATE OF DEATH

01447

Items 4, 13, 14 Film 0281 2-27-61 et

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magothy Beach c. LENGTH OF STAY IN lb 6 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magothy Beach d. STREET ADDRESS Riverside Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick William Middle Heikel Last 4. DATE OF DEATH Feb. 12, 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 25, 1885 9. AGE (In years last birthday) 75 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Contractor		10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Heikel		14. MOTHER'S MAIDEN NAME Johana Scheir	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Catherine Heikel Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 DUE TO acute pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Antenarobotic Cardiovascular disease 2 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate gland 11 years		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 10 1959 to February 12 1961 , that (I) (we) last saw the deceased alive on Feb. 7 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin 22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Feb. 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. 23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR DATE FEB 16 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1468

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01438

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,		c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Third Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month February Day 26, Year 1961		9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
3. NAME OF DECEASED (Type or print) First AMELIA Middle J. Last HELMER		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17th July '74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Lockmann		14. MOTHER'S MAIDEN NAME (Unknown) Rose		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Stensberry, Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs 10-12 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from Jan 16 19 61 to Feb 26 19 61 , that (I) (we) last saw the deceased alive on Feb 26 19 61 , and that death occurred at 11 M, from the causes and on the date stated above.		22a. SIGNATURE Chas. L. Ball Jr.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Linthicum Md.		22b. DATE SIGNED 2/28/61		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1st March 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Brooklyn, RFD, Maryland		25a. REC'D BY REGISTRAR DATE MAR 3 '61	
24. FUNERAL DIRECTOR'S SIGNATURE R. P. Bright		ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



1448
CENTRAL OF DENIA
STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1469 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 7, 22b Film G282 3/9/61 et											
01449											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Indiana					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Curtis Bay						c. LENGTH OF STAY IN 1b Indianapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Coast Guard Dispensary						d. STREET ADDRESS 1049 Blaine Street					
3. NAME OF DECEASED (Type or print) HAROLD ALAN HOWARD						4. DATE OF DEATH Month Day Year February 28 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1922		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.M.C.				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy				11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack L. Hobbs				14. MOTHER'S MAIDEN NAME Frances Hobbs (Maiden Name Unknown)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes June 7, 1942				16. SOCIAL SECURITY NO. 316-16-0497				17. INFORMANT U.S. Elohim Records, Norfolk, Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease											
420.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 3/1/61						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal						22b. DATE THEREOF 3-1-61		22c. NAME OF CEMETERY OR CREMATORY Local Funeral Home		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR Edw. B. Robertson Funeral Home, Inc.						ADDRESS 4306 - Belair Rd., Baltimore 6, Md.		24a. REC'D BY REGISTRAR MAR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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June 1960

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1470

01450

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8 years 9 mos. 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1419 Madison Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Ellen Johns		4. DATE OF DEATH Month 2 Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/91
9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 0 Days 0		10. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Blair		14. MOTHER'S MAIDEN NAME Annie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Tamponade DUE TO (b) Ruptured Aortic Aneurysm DUE TO (c) Syphilis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chromophobe Adenoma of Pituitary			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/7/1951 to 2/23/1961, that (I) (we) last saw the deceased alive on 2/23/1961, and that death occurred at 3:49 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 2/23/61	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/28/61	23c. NAME OF CEMETERY OR CREMATORY Mount Airy	23d. LOCATION (City, town or county) Baltimore (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE C.O. Wilson		25a. REC'D BY REGISTRAR FEB 27 1961	25b. REGISTRAR'S SIGNATURE L. Thane

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1470

Washington City

Washington

Washington

8 years
8 days

Washington

1113 Madison Avenue

Crownville State Hospital

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Johns

Allen

John

Patricia

John

Johns

John

U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1471											
01451											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 20 years 8 mos. 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jennie Jones						4. DATE OF DEATH 2 19 61					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dennis Barnett						14. MOTHER'S MAIDEN NAME Martha Overton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome asso. with Senile Brain Disease w. Psychosis										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/24/1961 to 2/19/1961 , that (I) (we) last saw the deceased alive on 2/19/1961 , and that death occurred at 12:15 a.m. from the causes and on the date stated above.											
22a. SIGNATURE L. Benedict, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 2/19/61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.						22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 28 Feb. 61		23c. NAME OF CEMETERY OR CREMATION Univ. of Md.		23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II						ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
15M 9/59

1472

1

Maryland

1472

01452

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island		c. LENGTH OF STAY IN 1b X		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X		d. STREET ADDRESS 1 Skippers Row		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur Rhodes Knight		First Arthur		Middle Rhodes		Last Knight		4. DATE OF DEATH Feb. 4, 1961		Month Feb.		Day 4		Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 10, 1886		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consulting Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? 									
13. FATHER'S NAME Arthur Knight		14. MOTHER'S MAIDEN NAME Mary Howland													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-1554		17. INFORMANT Mrs. Seaton Reed-Butler, Indiana		Address 									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerotic Heart Disease DUE TO 		INTERVAL BETWEEN ONSET AND DEATH minutes year +													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gibson Is		20f. (City or town) Anne Arundel Md.		(County) 		(State) 					
21. I certify that (I) (this hospital) attended the deceased from 2/4 19 61 to 2/4 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 1:45 PM , from the causes and on the date stated above.		22a. SIGNATURE Robert E. Cooke		M.D. ATTENDING PHYSICIAN 2/4/61		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/4/61							
22c. PHYSICIAN'S NAME (Type) Robert E. Cooke MD.		22d. ADDRESS Gibson Is, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2-9-61		23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City, town, or county) Springfield, Ohio		(State) 							
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Dickner & Sons		ADDRESS Balto 17, Md.		25a. REC'D BY REGISTRAR DATE 2-8-61		25b. REGISTRAR'S SIGNATURE Conrad E. Fowles									

11553

CERTIFICATE OF DEATH

1432

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Date of registration

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1473

CERTIFICATE OF DEATH

Reg. Dist. No. 01453

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>809 2nd Ave. Marley</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>KOMIN</u> Last <u>KOMIN</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11, 1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Car Loading Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Albert Komin</u>				14. MOTHER'S MAIDEN NAME <u>Caroline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-14-1670</u>			
17. INFORMANT <u>Albert J. Komin</u>				Address <u>1801 August Ave. Balto.-22-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordial Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Angiostenosis from Atherosclerotic Lesions</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>9 Jan. 1961</u> , to <u>29 Jan. 1961</u> , that I last saw the deceased alive on <u>29 Jan. 1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Melvin H. Crocker</u> M.D.				DATE SIGNED <u>2-7-61</u>			
PHYSICIAN'S NAME (Type) <u>Melvin H. Crocker, M. D.</u>				ADDRESS (Street, city or town, state) <u>Baltimore 2, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cwach</u>				ADDRESS <u>1211 Chesaco Ave. Balto.-6</u>		24a. REC'D BY REGISTRAR DATE FEB 10 '61	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p>	
<p>10. DATE OF DEATH</p> <p>11. TIME OF DEATH</p> <p>12. PLACE OF DEATH</p>		<p>13. CAUSE OF DEATH</p> <p>14. MANNER OF DEATH</p>	
<p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p>		<p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>20. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>21. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>22. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>23. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>24. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>25. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>26. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>27. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>28. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>29. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>30. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>31. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>32. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>33. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>34. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>35. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>36. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>37. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>38. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>39. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>40. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>41. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>42. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>43. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>44. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>45. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>46. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>47. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>48. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>49. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>50. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>51. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>52. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>53. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>54. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>55. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>56. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>57. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>58. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>59. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>60. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>61. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>62. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>63. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>64. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>65. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>66. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>67. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>68. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>69. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>70. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>71. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>72. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>73. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>74. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>75. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>76. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>77. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>78. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>79. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>80. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>81. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>82. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>83. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>84. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>85. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>86. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>87. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>88. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>89. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>90. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>91. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>92. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>93. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>94. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>95. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>96. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>97. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>98. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	
<p>99. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>100. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>		<p>101. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p> <p>102. SIGNATURE OF DECEASED'S NEAREST RELATIVE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1474
CERTIFICATE OF DEATH

Reg. Dist. No.

01454

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 38 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1, Box 256		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ZOFIA (SOPHIE) KOZLOWSKA		4. DATE OF DEATH February 4, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1879
9a. AGE (In years last birthday) 81 yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Helinski		14. MOTHER'S MAIDEN NAME Victoria Pleban	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Stella Tipton, Rte. 1, Box 256, Severn, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterior sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1960, to Feb 4 1961, that I last saw the deceased alive on Feb 4 1961, and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward G. Skerritt M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 62m6-1/15 Md 2-5-61	
PHYSICIAN'S NAME (Type) Edward G. Skerritt		Gambrills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/61	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, State, County) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.F. SADOWSKI & SONS, 1808 EASTERN AVE		24a. REC'D BY REGISTRAR DATE FEB 7 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Skerritt	

10. *How many times have you been in a fight with your partner?*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01455**

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General Hosp.</u>				d. STREET ADDRESS <u>19, F.D. Annapolis</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Verbal</u> <u>Laster</u>				4. DATE OF DEATH Month Day Year <u>2-9-1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb 2-1919</u>		9. AGE (In years last birthday) <u>42</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wheat Corn Etc</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>James W. Laster</u>				14. MOTHER'S MAIDEN NAME <u>Rate Senghush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mildred Laster</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>434-4</u> IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>				DATE SIGNED <u>2-9-61</u>			
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist</u>			
22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>				ADDRESS <u>Annapolis Md</u>			
24a. REC'D BY REGISTRAR <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF WARDEN	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF PATROLMAN	
28. SIGNATURE OF TRAFFIC OFFICER		29. SIGNATURE OF STREET CLEANSER		30. SIGNATURE OF SANITARY COMMISSIONER	
31. SIGNATURE OF HEALTH COMMISSIONER		32. SIGNATURE OF BOARD OF HEALTH		33. SIGNATURE OF BOARD OF CHARITY	
34. SIGNATURE OF BOARD OF ALMONDS		35. SIGNATURE OF BOARD OF AGING		36. SIGNATURE OF BOARD OF EDUCATION	
37. SIGNATURE OF BOARD OF FIRE PREVENTION		38. SIGNATURE OF BOARD OF FIRE INSURANCE		39. SIGNATURE OF BOARD OF FIRE PROTECTION	
40. SIGNATURE OF BOARD OF FIRE SAFETY		41. SIGNATURE OF BOARD OF FIRE INVESTIGATION		42. SIGNATURE OF BOARD OF FIRE PREVENTION	
43. SIGNATURE OF BOARD OF FIRE PROTECTION		44. SIGNATURE OF BOARD OF FIRE SAFETY		45. SIGNATURE OF BOARD OF FIRE INVESTIGATION	
46. SIGNATURE OF BOARD OF FIRE PREVENTION		47. SIGNATURE OF BOARD OF FIRE PROTECTION		48. SIGNATURE OF BOARD OF FIRE SAFETY	
49. SIGNATURE OF BOARD OF FIRE INVESTIGATION		50. SIGNATURE OF BOARD OF FIRE PREVENTION		51. SIGNATURE OF BOARD OF FIRE PROTECTION	
52. SIGNATURE OF BOARD OF FIRE SAFETY		53. SIGNATURE OF BOARD OF FIRE INVESTIGATION		54. SIGNATURE OF BOARD OF FIRE PREVENTION	
55. SIGNATURE OF BOARD OF FIRE PROTECTION		56. SIGNATURE OF BOARD OF FIRE SAFETY		57. SIGNATURE OF BOARD OF FIRE INVESTIGATION	
58. SIGNATURE OF BOARD OF FIRE PREVENTION		59. SIGNATURE OF BOARD OF FIRE PROTECTION		60. SIGNATURE OF BOARD OF FIRE SAFETY	
61. SIGNATURE OF BOARD OF FIRE INVESTIGATION		62. SIGNATURE OF BOARD OF FIRE PREVENTION		63. SIGNATURE OF BOARD OF FIRE PROTECTION	
64. SIGNATURE OF BOARD OF FIRE SAFETY		65. SIGNATURE OF BOARD OF FIRE INVESTIGATION		66. SIGNATURE OF BOARD OF FIRE PREVENTION	
67. SIGNATURE OF BOARD OF FIRE PROTECTION		68. SIGNATURE OF BOARD OF FIRE SAFETY		69. SIGNATURE OF BOARD OF FIRE INVESTIGATION	
70. SIGNATURE OF BOARD OF FIRE PREVENTION		71. SIGNATURE OF BOARD OF FIRE PROTECTION		72. SIGNATURE OF BOARD OF FIRE SAFETY	
73. SIGNATURE OF BOARD OF FIRE INVESTIGATION		74. SIGNATURE OF BOARD OF FIRE PREVENTION		75. SIGNATURE OF BOARD OF FIRE PROTECTION	
76. SIGNATURE OF BOARD OF FIRE SAFETY		77. SIGNATURE OF BOARD OF FIRE INVESTIGATION		78. SIGNATURE OF BOARD OF FIRE PREVENTION	
79. SIGNATURE OF BOARD OF FIRE PROTECTION		80. SIGNATURE OF BOARD OF FIRE SAFETY		81. SIGNATURE OF BOARD OF FIRE INVESTIGATION	
82. SIGNATURE OF BOARD OF FIRE PREVENTION		83. SIGNATURE OF BOARD OF FIRE PROTECTION		84. SIGNATURE OF BOARD OF FIRE SAFETY	
85. SIGNATURE OF BOARD OF FIRE INVESTIGATION		86. SIGNATURE OF BOARD OF FIRE PREVENTION		87. SIGNATURE OF BOARD OF FIRE PROTECTION	
88. SIGNATURE OF BOARD OF FIRE SAFETY		89. SIGNATURE OF BOARD OF FIRE INVESTIGATION		90. SIGNATURE OF BOARD OF FIRE PREVENTION	
91. SIGNATURE OF BOARD OF FIRE PROTECTION		92. SIGNATURE OF BOARD OF FIRE SAFETY		93. SIGNATURE OF BOARD OF FIRE INVESTIGATION	
94. SIGNATURE OF BOARD OF FIRE PREVENTION		95. SIGNATURE OF BOARD OF FIRE PROTECTION		96. SIGNATURE OF BOARD OF FIRE SAFETY	
97. SIGNATURE OF BOARD OF FIRE INVESTIGATION		98. SIGNATURE OF BOARD OF FIRE PREVENTION		99. SIGNATURE OF BOARD OF FIRE PROTECTION	
100. SIGNATURE OF BOARD OF FIRE SAFETY		101. SIGNATURE OF BOARD OF FIRE INVESTIGATION		102. SIGNATURE OF BOARD OF FIRE PREVENTION	

ORIGINAL FILED IN

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1478

CERTIFICATE OF DEATH

Reg. Dist. No. 01456

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 11 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MD.				d. STREET ADDRESS 712 GIDDINGS AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First RUSSELL		Middle DURR		Last LATIMER	
4. DATE OF DEATH		Month FEB		Day 11		Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 DEC 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME RALPH MUNLIN DURR				14. MOTHER'S MAIDEN NAME ACHSAR MARTHA SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - -		17. INFORMANT USNH HOSPITAL		Address ANNAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMATOSIS (RECTUM) DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS OVER 1 1/2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 JULY , 19 60 , to 11 FEB , 19 61 , that I last saw the deceased alive on 11 FEB , 19 61 , and that death occurred at 9:33A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USNH ANNAPOLIS, MD. 2-11-61							
ACTUAL SIGNATURE S. B. HILTABIDLE				M.D. USNH ANNAPOLIS, MD.			
PHYSICIAN'S NAME (Type) S. B. HILTABIDLE LT MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-1961		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sins				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE FEB 14 '61	
				24b. REGISTRAR'S SIGNATURE Charles E. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01457

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN lb Box 69 Route 2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sethille Leach				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Sethille Leach		First Sethille		Middle Leach		Last Leach		4. DATE OF DEATH Month Feb. Day 3 Year 19 61							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/03		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57		IF UNDER 24 HRS. Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Snowhil, Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ? Phelps						14. MOTHER'S MAIDEN NAME ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Daughter Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charred to death 7/6.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Few seconds					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fire broke out in her home and she could be rescued not											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2.AM p.m. 2/3/61 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Severn		(County) A.A.		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Gustave H. Faubert				EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/8/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or country) (State) Belair, Maryland		23. FUNERAL DIRECTOR Hopping & Kirkley, Glen Burnie, Md.					
24a. REC'D BY REGISTRAR FEB 7 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

1-1-42

Time Arrived

Leave

Box 69 Route 2

Johnnie L. Lach

27

3/15/42

USA

Shawville, Va.

Honorable

Police

Lawyer

Charged to death

few seconds

not

Five broke out under nose and she could be released

x

2. AM
3/15/42

Boys

X home

Ms.

3/15/42
Glen Lumsden, Va.

x

Gustave H. Varnert, D.

1
 1478
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 01458

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pasadena</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 498 Pasadena</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Thomas Lee</u>				4. DATE OF DEATH Month Day Year <u>Feb. 6 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1900</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. Milton Lee</u>				14. MOTHER'S MAIDEN NAME <u>Ola Mae -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215-12-4663</u>		17. INFORMANT Address <u>Lauraine Lee (wife) same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>- DUE TO - and Neurovascular syphilis</u> (c) <u>Neurovascular syphilis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 6 1961</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C. Earl Hill</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. Earl Hill, M.D.</u>				22d. ADDRESS <u>7819 Bridge Drive, Balto. 26</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/10/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		23d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marshall P. Hays 638 N. GILMORE ST BALTO 17 MD</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

1472



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1479
1479
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01459

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stevenson Rd - Rt. 1 - Box 443 A</u>		d. STREET ADDRESS <u>Stevenson Rd - Rt. 1 - Box 443 A</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A</u> Last <u>Liebno</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31 - 1960</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter D. Liebno</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Heinz</u> SAME as NO # 2	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Walter D. Liebno</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe upper respiratory infection</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> 19 <u>61</u> to <u>2/22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/22</u> 19 <u>61</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED. <u>2/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. W. SCHEYE MD.</u>		22d. ADDRESS <u>3230 MOUNTAIN RD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Feb 24 - 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Singleton Farm Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 24 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1-2-3

DATE OF DEATH

19

19

19

19

19

John A. Thompson, M.D.

1480

CERTIFICATE OF DEATH

Reg. Dist. No.

01460

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>KNOLLWOOD MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STEND</u> First Middle Last		4. DATE OF DEATH <u>2-26-61</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm, Denmark</u>	
11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Christian Madsen</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 422.1 DUE TO, <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, <u>C.V. Disease</u> (b) <u>C.V. Disease</u> (c) <u>C.V. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19, to <u>1961</u> , 19, that I last saw the deceased alive on <u>2-15-61</u> , 19, and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u>		ADDRESS (Street, city or town, state) <u>Severna Park MD</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>		DATE SIGNED <u>2-26-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>3-2-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill PK</u>	22d. LOCATION (City, town, or county) (State) <u>Berea, Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClully Funeral Home</u>		ADDRESS <u>130 E Fort Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

1480

NEW YORK

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1481

01461

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lake Shore, Pasadena,		c. LENGTH OF STAY IN lb 2 years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Patrick Maguire		4. DATE OF DEATH February 13 19 61		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/99		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor.		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick Maguire		14. MOTHER'S MAIDEN NAME Mary Black		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Mary Maguire (wife)		17. INFORMANT Mrs. Mary Maguire (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) Sudden		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Gustave H. Faubert, M.D.		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/14/61		Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Anthony S. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-61		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR Amg Pickers Sons		24a. REC'D BY REGISTRAR DATE FEB 17 '61		24b. REGISTRAR'S SIGNATURE Anthony S. Kraus		24c. REGISTRAR'S SIGNATURE Anthony S. Kraus		24d. REGISTRAR'S SIGNATURE Anthony S. Kraus	

1931

Anna (Mabel)

Lane Street, Pasadena,

Box 91, Idaho Falls,

James Patrick (Mabel)

Building Contractor, Boise,

Patrick (Mabel)

No.

Mrs. Mary (Mabel) (Mabel)

Temporary Custodian

X

X

2/11/31

Miss (Mabel) (Mabel)

Quincy H. (Mabel) (Mabel)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
1482
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01462

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1133 S. Sharp Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Will Maxwell		First Middle Last		4. DATE OF DEATH February 21, 1961	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-22-1880		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E. Maxwell		14. MOTHER'S MAIDEN NAME Lillian Smothers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 1 Unknown		17. INFORMANT Mrs. Eliz. Johnson Balto. D.P.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422-1 DUE TO 422-1 (c) 422-1		INTERVAL BETWEEN ONSET AND DEATH Over 6 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING TO DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1960 to Feb. 21, 1961 , that (I) (we) last saw the deceased alive on Feb. 18, 1961 , and that death occurred at 10A M, from the causes and on the date stated above.					
22a. SIGNATURE James M. Pair		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-21-1961	
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Ave., Balto., Md.		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

1482

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

01-12

Blank form with horizontal lines for text entry.

CERTIFICATE OF DEATH

Reg. Dist. No.

01463

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Manor Nur.Hm.		d. STREET ADDRESS 22 Georgia Ave,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Mayers Last Mayers		4. DATE OF DEATH Month 2 Day 4 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/77
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bush		14. MOTHER'S MAIDEN NAME Mary L.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Family		Address Blk	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X AZOTEMIA DUE TO (b) Nephrosclerosis DUE TO (c) 8 years		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY , 19 52 to Feb , 19 61 , that I last saw the deceased alive on February 2 , 19 61 , and that death occurred at 4 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. McDonald M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Glen Burnie Md 2/4/61	
PHYSICIAN'S NAME (Type) Glen Burnie			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 2/7/61	
22c. NAME OF CEMETERY OR CREMATORY Oaklawn		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		ADDRESS 130 E. Fort Ave.	
24a. REC'D BY REGISTRAR FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1483

Vertical stamp: EXAMINED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. GROOM		M		35		W		1898		BALTIMORE, MD		1933		BALTIMORE, MD		10:00 AM		HEART DISEASE		NATURAL		J. H. GROOM		J. H. GROOM		J. H. GROOM		J. H. GROOM	
16. FULL NAME OF DECEASED		17. SEX		18. AGE		19. RACE		20. DATE OF BIRTH		21. PLACE OF BIRTH		22. DATE OF DEATH		23. PLACE OF DEATH		24. TIME OF DEATH		25. CAUSE OF DEATH		26. MANNER OF DEATH		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF WITNESSES		30. SIGNATURE OF DECEASED	
JAMES H. GROOM		M		35		W		1898		BALTIMORE, MD		1933		BALTIMORE, MD		10:00 AM		HEART DISEASE		NATURAL		J. H. GROOM		J. H. GROOM		J. H. GROOM		J. H. GROOM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1484
CERTIFICATE OF DEATH

01464

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Abram D. Mullenax		First Middle Last		4. DATE OF DEATH February 27 1961		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 March 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (ret)		10b. KIND OF BUSINESS OR INDUSTRY Self-Emp.		11. BIRTHPLACE (County & State, or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and date of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Max Mullenax		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased from Feb. 23, 1961 to Feb. 27, 1961 , that (I) (or) saw the deceased alive on Feb. 27, 1961 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Edward S Beck				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/27/61	
22c. PHYSICIAN'S NAME (Type) Dr. Edward Beck				22d. ADDRESS Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2nd March '61		23c. NAME OF CEMETERY OR CREMATORY Baldwin Church Cem		23d. LOCATION (City, town or county) (State) Millersville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Singleton				ADDRESS Glen Burnie Md.		25a. REC'D BY REGISTRAR DATE MAR 1 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			

1961

Maryland
Anne Arundel
Biba

Annapolis
Anne Arundel

Anne Arundel General Hospital

February 27

Mallory

D.

Adrian

Male
White
x

Franklin St., Annapolis, Md.

Dr. Edward Beck

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1485

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01465

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>5 years 9 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>919 Mc Donough</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Myers</u> Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jim Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy —</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records (Mrs Laura Foster)</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO <u>DECURBITAL SORES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>INTRA TROCHANTERIC FRACTURE OF L. HIP</u> (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PSYCHOPHRENIC REACTION - CHRON. UNDIFFERENTIATED TYPE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>12/6/60</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>PAT. FELL IN BATH ROOM</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>2</u> <u>12</u> <u>6</u> <u>1961</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CROWNSSVILLE STATE HOSPITAL</u>		20f. (City or town) (County) (State) <u>CROWNSSVILLE STATE HOSPITAL</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> 19 <u>60</u> to <u>2-18</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-18</u> 19 <u>61</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict M.D.</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>CROWNSSVILLE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>A.A. County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Frank</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	
25c. DATE <u>FEB 23 '61</u>		25d. <u>—</u>	

CERTIFICATE OF SALE

1483

1



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1486

CERTIFICATE OF DEATH

Reg. Dist. No.

01466

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a. a.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Manor Nursing Home		d. STREET ADDRESS Rock Creek Park	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Nicholson		4. DATE OF DEATH Month February Day 5 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1875
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Culver, Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-22-8293	
17. INFORMANT Mrs. Bertha M. Martin, Rock Creek Park, Pasadena, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral infarction DUE TO 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis of cranial vessel. DUE TO (c) coronary artery disease, hypertension INTERVAL BETWEEN ONSET AND DEATH 1 week. ? dental.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/21 , 19 60 , to 2/5 , 19 61 , that I last saw the deceased alive on 2/1 , 19 61 , and that death occurred at 2:40 a. m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 CHATEAUX ST ANNAPOLIS DATE SIGNED 2/5/61 ACTUAL SIGNATURE GEORGE A. CHURCH M.D. PHYSICIAN'S NAME (Type) GEORGE A. CHURCH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-7-61	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore		24a. REC'D BY REGISTRAR DATE FEB 8 '61	
24b. REGISTRAR'S SIGNATURE Anna P. Cook			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1487

01467

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Herald Harbor Crownsville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsmere Middle Northrup Last Feb.		4. DATE OF DEATH Month Feb. Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Salesman	
11. BIRTHPLACE (County & State, or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Personal Papers of Deceased		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) PREVIOUS CEREBRAL THROMBOSES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-1-61 to 2-4-61 , that (I) (we) last saw the deceased alive on 2-1-61 , and that death occurred at 6:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.			
22b. PHYSICIAN'S NAME (Type) Edward S. Beck			
22c. ADDRESS Franklin St. Annapolis, Md. 2-4-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 7, 61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 8 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1488

CERTIFICATE OF DEATH

01468

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence Before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>			d. STREET ADDRESS <u>89 Charles St.</u>		
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>PARKER</u> Last <u>PARKER</u>			4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1886</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>William A. Henderson</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Carr</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>583 X</u>		
17. INFORMANT <u>Sarah Green</u>			Address <u>108 South Street</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Feb 13</u> 19 <u>61</u> to <u>Feb 13</u> 19 <u>61</u> ; that (I) (the hospital) saw the deceased alive on <u>Feb 13</u> 19 <u>61</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Faye W. Allen</u>			22b. DATE SIGNED <u>2/14/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>			22d. ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	
23d. LOCATION (City, town or county) <u>Annapolis Md.</u>		23e. (State) <u>Md.</u>		23f. (Country) <u>U.S.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>			24b. ADDRESS <u>Annapolis Md.</u>		
25a. REC'D BY REGISTRAR <u>Feb 15 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

1488

9-6-1876 77

Richard H. Henshaw

William A. Henshaw

(1)

Richard Henshaw

Richard Henshaw
William A. Henshaw

Richard Henshaw

CERTIFICATE OF DEATH

01469

Reg. Dist. No.

1489

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Maryland		COUNTY a. a.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Severna Pk.				TOWN Severna Park			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 Hodges Lane				STREET ADDRESS (If rural give location) 500 Hodges Lane			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) HAZEL J. (Middle) PFEIFFER (Last)				(Month) FEB (Day) 7 (Year) 19 61			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH 5/21/05	9. AGE last birthday 55 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.J.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Adolph Burkhardt				14. MOTHER'S MAIDEN NAME Emily Kramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Family Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Acute pulmonary oedema				INTERVAL BETWEEN ONSET AND DEATH Hours			
ANTECEDENT CAUSE(S) DUE TO (B) Mitral stenosis				Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Rheumatic fever.				Years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/21 , 19 61 , to 2/7 , 19 61 , that I last saw the deceased alive on 2/7 , 19 61 , and that death occurred at 12 M, from the causes and on the date stated above.							
SIGNATURE Gerard Church		M.D. 121 Cathedral St - Annapolis Md 2/7/61		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) B		DATE THEREOF 2/10/61		NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		LOCATION (City, town, or county) (State) Glen Burnie, Md/	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Arthur S. F...		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE FEB 9 '61				McCully Funeral Homes 130 E. Fort Ave.			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55-10M

CERTIFICATE OF DEATH

1933

A. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED
 DATE OF DEATH
 PLACE OF DEATH

SEX
 AGE

CAUSE OF DEATH
 MANNER OF DEATH

EDUCATION
 OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

DATE OF DEATH

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1490

01470

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>167 King Geo St</u>		d. STREET ADDRESS <u>167 King Geo St</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine E.</u> Middle <u>Popham</u> Last <u>Popham</u>		4. DATE OF DEATH Month <u>2-</u> Day <u>7-</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leonard B. Popham</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Joseph T. Meekins</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac Dehydration</u> DUE TO <u>Arteriosclerosis - Cardio-Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/6/61</u> to <u>2/7/61</u> , that (I) (we) last saw the deceased alive on <u>2/6/61</u> , and that death occurred on <u>2/7/61</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Kraus</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-9-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Annes Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

01110

CERTIFICATE OF DEATH

1400

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01471

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Annapolis</u>		c. LENGTH OF STAY IN 1b <u>SEVERAL YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cape St Claire</u>		d. STREET ADDRESS <u>1 Cape St Claire</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Perry</u> First <u>A</u> Middle <u>PUGH</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1904</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perry A. Pugh</u>		14. MOTHER'S MAIDEN NAME <u>Lelba Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-8413</u>	
17. INFORMANT <u>Fanny</u> Address <u>Cape</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 3 4 5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Multiple sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>several years</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-28</u> , 19 <u>59</u> , to <u>2-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>61</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard C.R. Galt</u>		ADDRESS (Street, city or town, state) <u>Cape St Claire Rt 4</u> DATE SIGNED <u>2/25/61</u>	
PHYSICIAN'S NAME (Type) <u>Bernard C.R. GALT</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lynchburg Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Lawrence</u> ADDRESS <u>Severna R.</u>		24a. REC'D BY REGISTRAR <u>Severna R.</u> DATE <u>FEB 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Severna R.</u>			

CERTIFICATE OF DEATH

1941

<p>1. Name of deceased: <u>ALICE M. BROWN</u></p>		<p>2. Sex: <u>F</u></p>	
<p>3. Date of birth: <u>1885</u></p>		<p>4. Age: <u>56</u></p>	
<p>5. Place of birth: <u>MD</u></p>		<p>6. Race: <u>W</u></p>	
<p>7. Usual residence: <u>1234 E. BALTIMORE ST.</u></p>		<p>8. Date of death: <u>1941</u></p>	
<p>9. Cause of death: <u>Heart Disease</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>1941</u></p>		<p>14. Office of registration: <u>Baltimore</u></p>	

10. Department of Health, Baltimore, Md.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel			c. LENGTH OF STAY IN lb 2 mons		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Tackroom Brn 14 Laurel Racetrack					d. STREET ADDRESS 4423 Kane Place N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alfred Holcomb Pumphrey					4. DATE OF DEATH February 22 19 61						
5. SEX Male		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 22 1912		9. AGE (In years last birthday) 48 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom at Racetrack					10b. KIND OF BUSINESS OR INDUSTRY Racetrack		11. BIRTHPLACE (State or foreign country) Citizen Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Pumphrey					14. MOTHER'S MAIDEN NAME Mary Etta Ross						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2 577-12-0777		17. INFORMANT Mrs Ester Brown 4423 Kane Pl NE							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 420.1 (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gustave H. Faubert MD.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Gustave H. Faubert MD.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DATE SIGNED 2-22-61						
					Address (Street, city, town, or county) Glen Burnie, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-27-61		22c. NAME OF CEMETERY OR CREMATORY Balington Nst.		22d. LOCATION (City, town, or country) (State) Balington Va					
23. FUNERAL DIRECTOR Henry S. Washington & Son					ADDRESS 4925 Warm Ave		24a. REC'D BY REGISTRAR DATE FEB 28 '61				
							24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1493

01473

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 1 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 35 Hicks Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lorraine (none) RANDALL				4. DATE OF DEATH Month February Day 7 Year 19 61			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1961	
9. AGE (in years last birthday) 1		IF UNDER 1 YEAR Months 1 Days 11 Hours 25		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Oliver Franklin RANDALL				14. MOTHER'S MAIDEN NAME Katherine Delores Blake			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 776 X		17. INFORMANT Oliver F. Randall 35 Hicks Ave hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - Prematurity DUE TO (b) 776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 30 hr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from Feb. 5, 1961 , to Feb. 7, 1961 , that (I) (we) last saw the deceased alive on Feb. 7, 1961 , and that death occurred at 10:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James I. Hudson, Jr.				ATTENDING MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.				22d. ADDRESS River Club Estates, Edgewater, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-1961		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Beese				25a. REC'D BY REGISTRAR FEB 15 61		25b. REGISTRAR'S SIGNATURE Arthur S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1496

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01475

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle R. Last Roberts		4. DATE OF DEATH Month 2 Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Roberts		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 260x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, Hebephrenic 300.1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year How am 19 61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23/ 19 61 to 2/12/ 19 61 , that (I) (we) last saw the deceased alive on 2/12/ 19 61 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 2/14/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 24 Feb-60	
23c. NAME OF CEMETERY OR CREMATORY Union of Md.		23d. LOCATION (City, town or county) (State) Balt. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		25c. ADDRESS 108 W. Wash. St. Ann. Md.	

STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1497
CERTIFICATE OF DEATH

01476

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Robinson</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1906?</u>	
9. AGE (In years last birthday) <u>55</u>		10. IF UNDER 1 YEAR Months <u>55</u> Days <u>27</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Glomerulonephritis Acute</u> DUE TO (c) <u>Syphilitic Aortitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Syphilitic Aortitis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>2/27</u>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2/20</u>	
23. TIME OF INJURY Month, Day, Year Hour <u>2</u> e.m. <u>20</u> p.m. <u>19</u>		24. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2/20</u>		26. (City or town) (County) (State) <u>1961</u> to <u>2/27</u> <u>1961</u>	
27. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> to <u>2/27</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , and that death occurred at <u>4:30 a.m.</u> from the causes and on the date stated above.		28. SIGNATURE <u>L. Benedict, M.D.</u>	
29. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		30. ATTENDING PHYS. <input type="checkbox"/> 31. MED. DIRECTOR <input checked="" type="checkbox"/> 32. STAFF PHYS. <input type="checkbox"/> <u>2/27/61</u>	
33. ADDRESS <u>Crownsville State Hospital, Maryland</u>		34. DATE <u>2/27/61</u>	
35. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		36. DATE THEREOF <u>Mar 2/61</u>	
37. NAME OF CEMETERY OR CREMATORY <u>Int Calvary</u>		38. LOCATION (City, town or county) (State) <u>Balt.</u> <u>MD.</u>	
39. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. A. Rice</u>		40. ADDRESS <u>661 W. Bane St.</u>	
41. REC'D BY REGISTRAR <u>DATE MAR 3 '61</u>		42. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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John A. ...

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01474

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>211 Hillcrest Ave.</i>			d. STREET ADDRESS <i>1 211 Hillcrest Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Richard</i> Last <i>Richert</i>			4. DATE OF DEATH Month <i>Feb</i> Day <i>5</i> Year <i>1961</i>			
5. SEX <i>M</i>			6. COLOR OR RACE <i>W</i>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>2/13/05</i>			
9. AGE (In years last birthday) <i>55</i> yrs.			IF UNDER 1 YEAR Months <i>5</i> Days <i>13</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dr.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Acme Co.</i>			
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>			12. CITIZEN OF WHAT COUNTRY? <i>Ind.</i>			
13. FATHER'S NAME <i>Geo.</i>			14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>Family</i>			
17. INFORMANT <i>Family</i>			Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Subarachnoid Hemorrhage</i> DUE TO (b) <i>Rupture of Aneurysm of Blood vessel of Brain</i> DUE TO (c) <i>330X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>William V. Smith</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>FEB 5 1961</i> DATE SIGNED				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>2/9/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Woodlands</i>		
22d. LOCATION (City, town, or county)		(State)				
23. FUNERAL DIRECTOR <i>Richard</i>		ADDRESS <i>130 E. Fort Ave.</i>		24a. REC'D BY REGISTRAR <i>FEB 6 61</i>		
24b. REGISTRAR'S SIGNATURE <i>Arthur B. Thomas</i>		DATE				

0177

1407

DATE OF DEATH
TIME OF DEATH

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1498

01477

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 2, Box 213E	
3. NAME OF DECEASED (Type or print) Charles M. Russell		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired U.S. N.A.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Russell		14. MOTHER'S MAIDEN NAME Henrietta Eisenratt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 1777X		16. SOCIAL SECURITY NO. Anna M. Russell	
17. INFORMANT Anna M. Russell		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Annapolis		(County) Md	
20g. (State) Md		21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.	
22a. SIGNATURE Dr. Edwin Davis		22b. DATE SIGNED FEB 6 '61	
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Davis		22d. ADDRESS Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-5-1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cent		23d. LOCATION (City, town or county) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR Arthur L. Brand	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Arthur L. Brand	
DATE FEB 6 '61		DATE FEB 6 '61	

1488

James Arundel

Annapolis

Anne Arundel General Hospital

Charles

M.

X

White

Male

Retired

Maryland

U. S. A.

Edgewater

Rt. 2, Box 2132

Roseall

February 2

61

Maryland James Arundel

Dr. Edwin Davis

Cathedral St., Annapolis, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1499

01478

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 316 North Glenn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman A. Sands		4. DATE OF DEATH Month February Day 11 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Naval Station	9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Sands		14. MOTHER'S MAIDEN NAME Effie M. Freeman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 163X	
17. INFORMANT Louise Sands		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF LUNG DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 9 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from 2/8 to 2/11 , 19 61 , that (I) (you) saw the deceased alive on 2/10 , 19 61 , and that death occurred 4:25AM from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck 22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22b. DATE SIGNED 2/12/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 71 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION (City, town or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		25a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. H...	

100-400000

Amnapolis

Amnapolis General Hospital

Norman

A.

Send

February 11

1961

Male White

Maryland

U.S.A.

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1:25PM

1:25PM

1:25PM

1:25PM

11111

CERTIFICATE OF DEATH

1000

NAME OF DECEASED
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
AGE AT DEATH
SEX
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
BAPTISM
TESTIMONY
SIGNATURE OF MINISTER
SIGNATURE OF WITNESSES
DATE OF RECORD



1501
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

01480

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Annapolis</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>11</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>St. Agnes Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Edna</i> First <i>Simms</i> Middle Last				4. DATE OF DEATH Month <i>2</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Cal</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-6-1911</i>	
9. AGE (In years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Phillip Pulley</i>				14. MOTHER'S MAIDEN NAME <i>Bertha Herring</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>216-28-3235</i>			
17. INFORMANT <i>Charles Simms</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subacute Bacterial Endocarditis</i> 053.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pyelonephritis (Bilateral)</i> DUE TO (c) <i>Bacteraemia</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 21, 1961</i> to <i>Feb 2, 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb 2, 1961</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Theodore H. Johnson</i> M.D.				22b. DATE SIGNED <i>2/6/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Theodore H. Johnson, M. D.</i>				22d. ADDRESS <i>37 Calvert St., Annapolis, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-8-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Beesley</i>				25a. REC'D BY REGISTRAR <i>Anna M.D.</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				DATE <i>FEB 9 '61</i>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.



MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1502 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01481									
1. PLACE OF DEATH a. COUNTY Anne Arundel			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND Same b. COUNTY Same						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 1 Year			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 2 Box 325 Freetown						d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara Elizabeth Smith			First Middle Last		4. DATE OF DEATH February 20th 1961				
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Eastville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Kelly					14. MOTHER'S MAIDEN NAME Easter Kelly				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT James Smith (son)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 hours									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2/23/61		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or country) (State) Laurel, P. G. Co., Md.		
23. FUNERAL DIRECTOR William A. Jackson Funeral Home					ADDRESS 916 Penna. Ave.		24a. REC'D BY REGISTRAR FEB 23 '61		24b. REGISTRAR'S SIGNATURE Carlton S. Kinn
ACTUAL SIGNATURE Gustave H. Faubert, M.D.			EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2/20/61 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Glen Burnie, Md.				

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1
CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1503

01482

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>a a.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 S. Cherry Lane</i>				d. STREET ADDRESS <i>608 Sixth St</i>			
3. NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>O.</i> Last <i>Stokes</i>				4. DATE OF DEATH Month <i>2</i> - Day <i>17</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 15 1881</i>	
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John A. Stokes</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Ziegler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Mary E. Stokes</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 4 1958</i> to <i>2-17-1961</i> , that (I) (we) last saw the deceased alive on <i>2-17-1961</i> , and that death occurred at <i>12:30 PM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>James R. Martin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-19-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>				22d. ADDRESS <i>6 SHAW ST ANNAPOLIS, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-20-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sins</i>				ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 21 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1504
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01483

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 South St</u>		d. STREET ADDRESS <u>120 South St.</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie Starsbury Sturges</u>		4. DATE OF DEATH <u>25</u> <u>25</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Conner</u>		14. MOTHER'S MAIDEN NAME <u>Katie Sparks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sue Stevens</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma / uterine Pneumonia</u> DUE TO (b) <u>Carcinoma / uterus</u> DUE TO (c) <u>Hant</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-25-61</u> to <u>2-25-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-25-61</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22d. ADDRESS <u>66 Cathedral St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reed, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>DATE MAR 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>	

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1503

CERTIFICATE OF DEATH

Reg. Dist. No. 01485

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverdale & Inverness Roads</u>		4. STREET ADDRESS <u>Severna Park Rd</u>	
3. NAME OF DECEASED (Type or print) <u>KATRINA</u> <u>Swindell</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. DATE OF DEATH <u>2-5-61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Moser</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Box 221 Route #2</u>	
17. INFORMANT <u>Son Mr. J. Warren Swindell</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19____, to <u>1961</u> , 19____, that I last saw the deceased alive on <u>12-20-60</u> , 19____, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		ADDRESS (Street, city or town, State) <u>Severna Park Md 2-5-61</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>		DATE SIGNED <u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker Sons</u>		ADDRESS <u>Balto 17, Md.</u>	
24a. REC'D BY REGISTRAR <u>8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1506

CERTIFICATE OF DEATH

01486

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN lb <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Co GEN. HOSP</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u> d. STREET ADDRESS <u>1 RT # 1 Box 231 A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle Last <u>TEEL</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>12</u> Year <u>1961</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 14, 1871</u>	9. AGE (In years lost birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ANTON TREIBE</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA SNYDER</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>FAMILY</u> Address <u>ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral, basilar</u> DUE TO (b) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LOST.					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12 1961</u> to <u>Feb 12 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 12 1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis I. Codd</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 14, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS I. CODD, M.D.</u>		22d. ADDRESS <u>RTCHIE Highway SEVERNA Pk. MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MIEN HAVEN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>MIEN BURNIE MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barancko</u>		ADDRESS <u>SEVERNA Pk. MD.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 17 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		

04110

CERTIFICATE OF DEATH

1508



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is not executed within 24 hours after death, it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1507

01487

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in lb 17 years 6 mos. 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS Unknown RFD	
3. NAME OF DECEASED (Type or print) Alex Thomas		4. DATE OF DEATH Month 2 Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 2 Days 27 Hours 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Thomas		14. MOTHER'S MAIDEN NAME Lilly Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Aspiration Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome asso. w. Syphilis of the Central Nervous System Meningo-Encephalitic Type			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour 8:25 a.m. 19 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/25 to 2/27/61 , that (I) (we) last saw the deceased alive on 2/27/61 , and that death occurred at 9:25 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp		22b. DATE SIGNED 2/28/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/2/61	
23c. NAME OF CEMETERY OR CREMATORY Univ. Of Md.		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II		25a. REC'D BY REGISTRAR Mar 6 '61	
25b. REGISTRAR'S SIGNATURE William S. Hume			

7051

Exhibit 9

U.S. GOVERNMENT PRINTING OFFICE: 1964

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• **Intervall** (Zeit, Ort, ...): Zeitintervall, Ortsintervall, ...

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1008

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1508

Items 1, 8, 9 Film C280 2-10-61 et

Reg. Dist. No.

01488

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - MD.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Private home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS -</u> d. STREET ADDRESS <u>1 419 Second St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>E.</u> Last <u>TIGHMAN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Tull</u>		14. MOTHER'S MAIDEN NAME <u>Sally Collin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. N. W. Sadler</u>		Address <u>419 second St. Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 1443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>2-1-61</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2-4-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rehoboth Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rehoboth, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Miller</u>		24a. REC'D BY REGISTRAR <u>MD</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>
ADDRESS <u>Princess Anne</u>		DATE <u>2B 7 '61</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1898

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Medical Examiner _____		Signature of Coroner _____	
Date of Certificate _____		Office of Medical Examiner _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
15M 9/60

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1509

CERTIFICATE OF DEATH

Item 8 Film G282 3/7/61 mh

01489

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TOWN Ann	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Allec (Vordsky) VODORSKY		4. DATE OF DEATH Month 2 Day 25 Year 1961		5. AGE (In years last birthday) 74 yrs.	
6. SEX Male		7. COLOR OR RACE White		8. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger (Ref)		10b. KIND OF BUSINESS OR INDUSTRY Garment		11. BIRTHPLACE (County & State, or foreign country) U.S.S.R.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9612		17. INFORMANT Clyde Stacy - Lake Shore Dr., Pasadena, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiac failure DUE TO (c) Coronary disease		19. INTERVAL BETWEEN ONSET AND DEATH 3 hours months		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from 2/23/1961 to 2/25/1961 , that (I) (the undersigned) last saw the deceased alive on 2/24/1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above.		22a. SIGNATURE Gerard Church		22b. DATE SIGNED 2/25/61	
22c. PHYSICIAN'S NAME (Type) GIETANN CHURCH		22d. ADDRESS 121 PATHEMORAL ST ANNAPOLIS		22e. DATE 2/25/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 28th Feb - 1961		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
23d. LOCATION (City, town or county) (State) Glen Burnie Md.		24. FUNERAL DIRECTOR'S SIGNATURE R. V. Dingleden		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	
24a. ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAR 1 '61		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

1500

Anna Arnold

Harry Smith

Anna Arnold

Anna Arnold

Harry Smith

Box 25, Lake Shore Drive

One, Arnold General Hospital

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CERTIFICATE OF DEATH

Reg. Dist. No.

02656

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>5y. 4m. 13d.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1118 Etting St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Malinda</u> Middle <u>Elizabeth</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? 3-7-1880</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASS. WITH GEN. ARTERIOSCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>							
21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>55</u> , to <u>2/25/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/25/61</u> , 19 <u>61</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>				M.D. <u>CROWN SVILLE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				ADDRESS (Street, city or town, state) <u>CROWN SVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville, Md. VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. O. Wilson</u>				ADDRESS <u>1000 Brantley Ave.</u>		24a. REGULAR REGISTRAR DATE <u>MAR 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

050525

PAGE ONE

CERTIFICATE OF DEATH

1510

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. RACE W		4. DATE OF BIRTH 10-10-1928		5. PLACE OF BIRTH MOBILE, ALA.	
6. DATE OF DEATH 4-4-68		7. PLACE OF DEATH MEMPHIS, TENN.		8. CAUSE OF DEATH SHOOTING		9. MANNER OF DEATH HOMICIDE		10. MEDICAL EXAMINER JAMES EARL RAY	
11. FULL NAME OF NEXT OF KIN JAMES EARL RAY		12. ADDRESS OF NEXT OF KIN JAMES EARL RAY		13. CITY AND STATE OF NEXT OF KIN MEMPHIS, TENN.		14. RELATIONSHIP TO DECEASED HUSBAND		15. SIGNATURE OF NEXT OF KIN JAMES EARL RAY	
16. FULL NAME OF DECEASED JAMES EARL RAY		17. ADDRESS OF DECEASED JAMES EARL RAY		18. CITY AND STATE OF DECEASED MEMPHIS, TENN.		19. RELATIONSHIP TO DECEASED HUSBAND		20. SIGNATURE OF DECEASED JAMES EARL RAY	
21. FULL NAME OF DECEASED JAMES EARL RAY		22. ADDRESS OF DECEASED JAMES EARL RAY		23. CITY AND STATE OF DECEASED MEMPHIS, TENN.		24. RELATIONSHIP TO DECEASED HUSBAND		25. SIGNATURE OF DECEASED JAMES EARL RAY	
26. FULL NAME OF DECEASED JAMES EARL RAY		27. ADDRESS OF DECEASED JAMES EARL RAY		28. CITY AND STATE OF DECEASED MEMPHIS, TENN.		29. RELATIONSHIP TO DECEASED HUSBAND		30. SIGNATURE OF DECEASED JAMES EARL RAY	
31. FULL NAME OF DECEASED JAMES EARL RAY		32. ADDRESS OF DECEASED JAMES EARL RAY		33. CITY AND STATE OF DECEASED MEMPHIS, TENN.		34. RELATIONSHIP TO DECEASED HUSBAND		35. SIGNATURE OF DECEASED JAMES EARL RAY	
36. FULL NAME OF DECEASED JAMES EARL RAY		37. ADDRESS OF DECEASED JAMES EARL RAY		38. CITY AND STATE OF DECEASED MEMPHIS, TENN.		39. RELATIONSHIP TO DECEASED HUSBAND		40. SIGNATURE OF DECEASED JAMES EARL RAY	
41. FULL NAME OF DECEASED JAMES EARL RAY		42. ADDRESS OF DECEASED JAMES EARL RAY		43. CITY AND STATE OF DECEASED MEMPHIS, TENN.		44. RELATIONSHIP TO DECEASED HUSBAND		45. SIGNATURE OF DECEASED JAMES EARL RAY	
46. FULL NAME OF DECEASED JAMES EARL RAY		47. ADDRESS OF DECEASED JAMES EARL RAY		48. CITY AND STATE OF DECEASED MEMPHIS, TENN.		49. RELATIONSHIP TO DECEASED HUSBAND		50. SIGNATURE OF DECEASED JAMES EARL RAY	
51. FULL NAME OF DECEASED JAMES EARL RAY		52. ADDRESS OF DECEASED JAMES EARL RAY		53. CITY AND STATE OF DECEASED MEMPHIS, TENN.		54. RELATIONSHIP TO DECEASED HUSBAND		55. SIGNATURE OF DECEASED JAMES EARL RAY	
56. FULL NAME OF DECEASED JAMES EARL RAY		57. ADDRESS OF DECEASED JAMES EARL RAY		58. CITY AND STATE OF DECEASED MEMPHIS, TENN.		59. RELATIONSHIP TO DECEASED HUSBAND		60. SIGNATURE OF DECEASED JAMES EARL RAY	
61. FULL NAME OF DECEASED JAMES EARL RAY		62. ADDRESS OF DECEASED JAMES EARL RAY		63. CITY AND STATE OF DECEASED MEMPHIS, TENN.		64. RELATIONSHIP TO DECEASED HUSBAND		65. SIGNATURE OF DECEASED JAMES EARL RAY	
66. FULL NAME OF DECEASED JAMES EARL RAY		67. ADDRESS OF DECEASED JAMES EARL RAY		68. CITY AND STATE OF DECEASED MEMPHIS, TENN.		69. RELATIONSHIP TO DECEASED HUSBAND		70. SIGNATURE OF DECEASED JAMES EARL RAY	
71. FULL NAME OF DECEASED JAMES EARL RAY		72. ADDRESS OF DECEASED JAMES EARL RAY		73. CITY AND STATE OF DECEASED MEMPHIS, TENN.		74. RELATIONSHIP TO DECEASED HUSBAND		75. SIGNATURE OF DECEASED JAMES EARL RAY	
76. FULL NAME OF DECEASED JAMES EARL RAY		77. ADDRESS OF DECEASED JAMES EARL RAY		78. CITY AND STATE OF DECEASED MEMPHIS, TENN.		79. RELATIONSHIP TO DECEASED HUSBAND		80. SIGNATURE OF DECEASED JAMES EARL RAY	
81. FULL NAME OF DECEASED JAMES EARL RAY		82. ADDRESS OF DECEASED JAMES EARL RAY		83. CITY AND STATE OF DECEASED MEMPHIS, TENN.		84. RELATIONSHIP TO DECEASED HUSBAND		85. SIGNATURE OF DECEASED JAMES EARL RAY	
86. FULL NAME OF DECEASED JAMES EARL RAY		87. ADDRESS OF DECEASED JAMES EARL RAY		88. CITY AND STATE OF DECEASED MEMPHIS, TENN.		89. RELATIONSHIP TO DECEASED HUSBAND		90. SIGNATURE OF DECEASED JAMES EARL RAY	
91. FULL NAME OF DECEASED JAMES EARL RAY		92. ADDRESS OF DECEASED JAMES EARL RAY		93. CITY AND STATE OF DECEASED MEMPHIS, TENN.		94. RELATIONSHIP TO DECEASED HUSBAND		95. SIGNATURE OF DECEASED JAMES EARL RAY	
96. FULL NAME OF DECEASED JAMES EARL RAY		97. ADDRESS OF DECEASED JAMES EARL RAY		98. CITY AND STATE OF DECEASED MEMPHIS, TENN.		99. RELATIONSHIP TO DECEASED HUSBAND		100. SIGNATURE OF DECEASED JAMES EARL RAY	

1. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

2. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

3. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

4. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

5. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

6. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

7. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

8. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

9. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

10. I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1511											
CERTIFICATE OF DEATH											
01490											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1520 N. Eutaw Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 6 mos. 9 days			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 1520 N. Eutaw Place		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mae						4. DATE OF DEATH Last Winters Month 2 Day 15 Year 19 61					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/6/1900		9. AGE (In years last birth 60 yrs.) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. PLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Elizabeth Jones							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) with Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): Chronic Brain Syndrome asso with Cerebral Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Hour ----- e.m. ----- p.m. 19		20d. INJURY OCCURRED While ----- at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, etc.) -----		20f. (City or town) -----		20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 6/8/1960 to 2/15/1961 that (I) (we) last saw the deceased alive on 2/15/1961 and that death occurred at 8:15 from the causes and on the date stated above.											
22a. SIGNATURE Hildegard H. Reissmann 22c. PHYSICIAN'S NAME (Type) Hildegard H. Reissmann						22b. DATE 2/15/61		22d. ADDRESS Crownsville State Hospital, Maryland		22e. DATE 2/15/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/20/61		23c. NAME OF CEMETERY OR CREMATORY mt auburn		23d. LOCATION (City, town or county) (State) md			
24. FUNERAL DIRECTOR'S SIGNATURE Geo. S. Nelson						24b. ADDRESS 1348 N. Calhoun		25a. REC'D BY REGISTRAR FEB 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

01480

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Baltimore City

Maryland

Anne Arundel

Baltimore

6 mos. 9 days

Greenville

1530 N. Main Road

Greenville State Hospital

Intake

Jan

11/6/1980

X

Male

Female

Maryland

Unknown

Unemployed

Elizabeth Jones

Unknown

Hospital Records

Unknown

No

Illnesses

Arteriosclerotic Cardiovascular Disease

with Hypertension

Chronic Brain Syndrome also with Cerebral Arteriosclerosis

61

4/15

60

4/15

61

4/15

1/15/81

4/15

Greenville State Hospital, Maryland

Hildreth H. Robinson

[Handwritten signatures and notes at the bottom of the page]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1513

01492

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Shoreland Drive				d. STREET ADDRESS 3 Shoreland Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Faith Middle Young Last Young				4. DATE OF DEATH Month Feb. Day 26 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1960		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 5	IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Young				14. MOTHER'S MAIDEN NAME Martha Ann Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Young, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Asphyxia due to undetermined cause (c) Asphyxia due to undetermined cause							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26, 1961 to Feb 26, 1961 , that (I) (we) lost saw the deceased alive on Feb 26, 1961 , and that death occurred at 8AM , from the causes and on the date stated above.							
22a. SIGNATURE James W. Hayes				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James W. Hayes				22d. ADDRESS Medical Arts Bldg			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb 28, 61		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City, town, or county) (State) Glen Burnie Md	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKLEY				25a. REC'D BY REGISTRAR DATE MAR 2 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kneass	

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STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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